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Better Care, Better Experiences, Better Value

2013–16 Erie St. Clair Local Health Integration Network Integrated Health Service Plan 3

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

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Section 1: Executive Summary

The Erie St. Clair Local Health Integration Network (ESC LHIN) is one of 14 Local Health Integration Networks (LHINs) established in 2006 as agencies of the Government of Ontario. LHINs are responsible for the planning, funding, and integration of health services across the province. Erie St. Clair LHIN serves the communities of Chatham-Kent, Sarnia/Lambton, and Windsor/Essex, with a total population of approximately 640,000 people, and oversees an annual budget of $1.09 billion for the local health care services.

This document sets out our third *Integrated Health Service Plan* (IHSP 3). It provides a detailed overview of the key health system strategic directions we will pursue over the next three years (2013–16). It also details how these strategic directions will be executed in the short term (over 90-day planning cycles) through various tactical projects and actions intended to address established performance targets. The *Integrated Health Service Plan 3* builds on the Ministry of Health and Long-Term Care's (MOHLTC's) priorities, as outlined in *Ontario's Action Plan for Health Care*; local priorities, including ESC LHIN's second *Integrated Health Service Plan* (IHSP 2), which covered the period from 2010–13; as well as ESC LHIN's Vision: Better Care, Better Experiences, Better Value. Input was sought on the plan's development through community engagement with our health care community.

Erie St. Clair LHIN's focus over the next three years remains the same: to continue transformation and integration efforts aimed at providing the right services to meet expected demand, increased collaboration, stakeholder engagement in the decision making-process, and improved overall efficiency in the use of health care resources.

The *Integrated Health Service Plan 3*'s four key strategic priority areas for 2013–16 are:

1. Improved Outcomes in Alternate Level of Care (ALC)

   Rationale:

   Too often, people remain in hospital when an alternate level of care (ALC) is available and would serve them better — for instance, at home or in long-term care, where services can be better tailored to their needs. This negatively affects both patient flow and patient experience while driving up overall health care costs. The ALC rate for 2011–12 (fourth quarter) was 12.82%, above ESC LHIN's target rate of 12%. Erie St. Clair continues to have the highest proportion of ALC patients discharged to complex continuing care (CCC). The top three patient types for ALC days across the Erie St. Clair region are dementia, ischemic event of central nervous system, and heart failure without coronary angiogram.

2. Improved Outcomes in the Emergency Department (ED)

Rationale:

In ESC LHIN (and in Ontario generally), hospital emergency departments (EDs) continue to be the default portal through which many consumers gain access to health care. The resulting ED congestion is an indicator of overall health system performance, telling us how effectively our primary health care, community care, mental health, and hospital programs are working together to serve patients.

3. Improved Outcomes in Chronic Disease Management (CDM)

Rationale:

Chronic health conditions are rapidly increasing the overall burden of disease in the Erie St. Clair region. Compared to the province, the Erie St. Clair population has higher rates of occurrence for arthritis, asthma, diabetes, hypertension, mood disorder, chronic obstructive pulmonary disease (COPD), and heart disease. Of these conditions, the largest proportions of ED visits are associated with arthritis, heart disease, and COPD.

4. Improved Outcomes in Mental Health and Addictions

Rationale:

Mental health and addictions are traditionally underserviced areas, and consequently have a significant impact on emergency departments, acute settings, and community resources. In the region's EDs, for example, 77% of the mental health and addictions visits are associated with the following diagnoses: neuroses, stress-related and somatoform disorders, mood disorders, and mental and behavioural disorders due to psychoactive substance use.[1]

After identifying our overall strategic priorities, we initiated a more focused approach targeting "priority populations" (i.e., those most in need, and high users of the health care system), and identifying "hot spots" — defined geographic areas indicating patterns of evidence of higher utilization, or inappropriate utilization of health care resources (because other options for care do not exist).

Through community engagement, stakeholders were engaged to provide input on how to better address health care needs. The result is a list of priority tactics/projects (see Section 6) that will be started within the next 12 to 36 months; the aim is to produce results that better address the following ESC LHIN key performance measures:

[1] National Ambulatory Care Reporting System [NACRS], MOHLTC, *Health Results*.

- Percentage of ALC days reductions
- ED length of stay (LOS) non-admitted complex (Canadian Triage and Acuity Scale [CTAS] 1–3) reductions
- ED LOS non-admitted minor (CTAS 4–5) reductions
- Wait time (WT) for Community Care Access Centre (CCAC) in-home services reductions
- Repeat unplanned ED visits within 30 days for mental health and addictions reductions
- Readmissions within 30 days for selected case mix groups (CMGs)

The development of IHSP 3 was informed by a number of planning frameworks, guidelines, and tools. The plan also builds on previous work completed over the past six years. As we move forward with the implementation of the directions and tactics identified in IHSP 3, we will continue to incorporate the following key considerations into our work:

1. Embed quality improvement and learning strategies into our activities
2. Advance strategies related to the collective LHIN system-wide imperatives
3. Continue to implement a consistent and transparent approach to planning, priority setting, and decision-making
4. Continue to identify, advance, and measure performance indicators and targets that support the achievement of provincial and LHIN-level goals and priorities
5. Apply a variety of communication and engagement strategies and tactics, to ensure that interested parties have an opportunity to participate in their care decisions

The plan concludes with a preliminary suggestion of how ESC LHIN will address the budgetary impact of health system funding reform.

Section 2: Introduction and Context

Erie St. Clair Local Health Integration Network (ESC LHIN) Background

The Erie St. Clair Local Health Integration Network (ESC LHIN) is one of 14 Local Health Integration Networks (LHINs) in Ontario. The LHINs were established in 2006 to manage the planning, integration, performance, and funding of the health care system. This responsibility includes services delivered by:

- Hospitals
- Long-term care (LTC) homes
- Community Care Access Centres (CCACs)
- Community support service (CSS) agencies
- Mental health and addictions agencies
- Community health centres (CHCs)

As Crown agencies that work in partnership with the Ministry of Health and Long-Term Care (MOHLTC), LHINs provide leadership and accountability for the health care system at the local level and ensure that the health care needs of Ontarians are identified, coordinated, and addressed in a truly integrated system. Local accountability gives communities the opportunity to become involved in health care planning.

ESC LHIN serves approximately 640,000 people in the regions of Chatham-Kent, Sarnia/Lambton, and Windsor/Essex. The population includes immigrants (18.1%), seniors (15.8%; those aged 65+), Francophones (3.3%), and Aboriginal peoples (2.4%). Windsor/Essex comprises 62% of the population; Sarnia/Lambton, 20%; and Chatham-Kent, 18%.[2]

ESC LHIN oversees an annual budget of $1.09 billion for local health care services. Table 1 provides an overview of the funding disposition.

[2] Health Analytics Branch, MOHLTC, *MOHLTC Environmental Scan*.

Table 1: ESC LHIN Funding Allocations, 2012–13 (as of August 31, 2012)

Sector	2012–13 Budget (Millions)
Hospitals	$677.36
Long-term care	$183.11
Community Care Access Centre	$119.26
Mental health agencies	$31.89
Community health centres	$26.30
Community support services	$17.62
Addictions agencies	$8.90
Assisted living services	$6.28
Acquired brain injury	$1.46
Initiatives	$10.09
Subtotal	**$1,082.3**
ESC LHIN operations	$5.00
Grand Total	**$1.09 Billion**

Strategic Plan

In December 2011, ESC LHIN embarked on a six-month strategic planning process. A strategic plan was advanced in order to assist the ESC LHIN board in governing effectively, and with directional alignment.

The ESC LHIN board and staff engaged the wider health care community in a consultative process to obtain information on current-state issues, and future-state opportunities. As a result of the consultations, the board identified a number of preliminary strategic issues and needs that were consistent with a previous SWOT Analysis (see Appendix A), including:

- Fiscal sustainability (increased funding and quality pressures)
- Lack of consistent system leadership/management
- Lack of primary care strategy
- Challenges with respect to chronic disease (diabetes/obesity)
- Decreased capacity (organizational and system)
- Lack of integration/integrated behaviours
- Lack of profile/wrong profile (LHIN system)
- Heightened expectations ("Excellent Care for All"; access [equitable])

Strategic Vision

The strategic plan culminated with the creation of a revised Vision Statement for ESC LHIN: Better Care, Better Experiences, Better Value.

Mandate

Erie St. Clair LHIN's mandate is to create a local health care system that:

1. Generates better clinical and functional results, especially for the most vulnerable, fragile patients
2. Creates a more coordinated system that provides the right care at the right place and the right time, especially for the most vulnerable, fragile patients
3. Boldly transforms the health care system, positioning it to become a highly efficient and effective performance leader

Strategic Directions

The strategic plan developed a series of directions to guide the LHIN's activities:

Direction #1: Chronic Disease Management (CDM)
Objective: Realign the health care system so that people with chronic diseases receive better regular care, are better able to self-manage their conditions, and are less reliant on emergency and acute care services.

Direction #2: Bold, Focused Leadership
Objective: As leaders of local health care, make courageous decisions that create a more tightly integrated, better aligned, and sustainable system where people receive the best care possible.

Direction #3: Partnerships in Health Promotion
Objective: Create better links between all health promotion and prevention organizations so that people have better access to programs and information that help them live healthier lives.

Provincial and Local Influences

Over the past few years, a number of key directional health care planning documents were released by both provincial and local organizations. These documents were considered by ESC LHIN in determining priority directions and key populations for inclusion in the *Integrated Health Service Plan 3* (IHSP 3). The documentation reviewed included, but was not limited to the following:

- *Ontario's Action Plan for Health Care* (February 2012; see Section 3 for a summary of the plan)
- LHIN-system CEO's vision document — *Changing the Conversation* (April 2012)
- Dr. David Walker, *Caring for Our Aging Population and Addressing Alternate Level of Care* (June 2012)
- *Public Service for Ontarians: A Path to Sustainability and Excellence* (the Drummond Report, February 2012)
- ESC LHIN, *Leadership Council Directional Plans* (October 2012)
- Health Quality Ontario (HQO), *2012 Report on Ontario's Health Care System* (March 2012)
- Dr. G. Ross Baker, *Enhancing the Continuum of Care — Report on the Avoidable Hospitalization Advisory Panel* (November 2011)
- Dr. Sinha (lead), Ontario's Seniors Care Strategy (January 2013)
- LHIN Rehabilitation Network, *Rehabilitation System Strategic Plan for the Erie St. Clair Region* (September 2012)
- *Erie St. Clair Mental Health Strategic Plan* (November 2012)

Information from a review of the above documentation was grouped into a number of general-level strategic themes/directions, including:

- Promoting integration from a patient service perspective
- Managing care transitions (hospital to community)
- Improving efficiency (back office)
- Building system capacity and capability (Health-Based Allocation Model [HBAM] effect)
- Promoting and improving health maintenance (chronic disease management)
- Enhancing access to primary care
- Enhancing coordination, transitions, and standardization of care for targeted populations
- Implementing evidence-based practice to drive safety
- Maintaining achievement in access, accountability, and safety ("holding the gains")

The information was further assessed in order to identify the key priority populations that would be targeted for IHSP 3 (in alignment with provincial directions):

- High users of the health care system — focus on the 1% of users who consume a significant proportion of all health care resources, as well as the next 5% (those at risk of becoming high users)
- Seniors — focus on CDM. Key diagnoses of concern are chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and complications from diabetes

- Mental health clients — focus on:
  - people with serious, persistent, mental illness (SPMI)
  - people with schizophrenia
  - transitional-age youth
  - homeless people with SPMI
  - youth with eating disorders
  - older adults with responsive behaviours associated with mental health, addictions, dementia, or other neurological conditions (Behavioural Supports Ontario [BSO])
- Rehabilitation clients — focus on stroke, orthopaedic, and geriatric-frail population

Integrated Health Service Plan 3

The *Integrated Health Service Plan 3* is the strategic plan for integrating and improving health services in our region. The plan is consistent with ESC LHIN's Vision and the strategic directions of MOHLTC, and it sets out the priority areas that will guide ESC LHIN tactics/activities over the next three years. The plan also builds on the work of previous IHSPs.

Previous Integrated Health Service Strategic Aims

It has been six years since ESC LHIN completed its initial IHSP, and although we are making progress, there is still a lot of work to be done. Table 2 provides a snapshot of our comparative strategic directions over time.

Table 2: ESC LHIN Strategic Directions, 2006–16

IHSP 1 Strategic Directions (2006–09)	IHSP 2 Strategic Directions (2010–13)	IHSP 3 Strategic Directions (2013–16)
• Chronic disease management • Reducing dependence on hospital-based services • Supporting people at home • Back office/administrative integration • System navigation • Health human resources • Health promotion and illness prevention • Timely access to appropriate care and services	• Improved outcomes in alternate level of care • Improved outcomes in emergency department care • Improved outcomes in diabetes management (chronic disease management) • Improved outcomes in mental health and addictions • Improved outcomes in rehabilitation care and interventions	• Improved outcomes in ALC • Improved outcomes in the ED • Improved outcomes in chronic disease management • Improved outcomes in mental health and addictions

Over the past six years, ESC LHIN has strived to improve outcomes in four key areas:

1. Access to care
2. Quality enhancements
3. Cost effectiveness
4. Improved coordination/integration

Planning efforts will continue to target outcome improvements for these key areas through IHSP 3. Over the past three years, under the guidance of IHSP 2, considerable success has been achieved in the following initiatives:

- Improved access
  - Invested in transportation to decrease the incidence of social isolation for seniors, and to help them connect to health care services
  - Invested in the creation of additional convalescent care beds to help sustain acute care services
  - Invested in the creation of additional units for assisted living for seniors
  - Invested in the creation of assess and restore beds at Hôtel-Dieu Grace Hospital (HDGH) and Leamington District Memorial Hospital (LDMH), to improve outcomes for ALC patients in acute care beds
  - Invested in the creation of 60 interim LTC beds in Windsor/Essex
- Improved quality
  - Invested in standardized utilization tools
  - Invested in the establishment of a psychiatric assessment team in the ED at HDGH to enhance services for psychiatric patients presenting in ED
  - Invested in establishing geriatric emergency medicine (GEM) nurses in all hospital EDs
  - Invested in end-of-life teams and CDM teams
- Cost effectiveness
  - Worked with ESC CCAC to ensure that seniors continue to receive the care they need in a cost-effective, sustainable manner
  - Made timely funding recoveries and subsequently transferred funds to organizations facing strategic needs and pressures
  - Invested in installing Ontario Telemedicine Network (OTN) equipment and telemedicine nurses in all hospitals

- Co-ordination/integration
  - Enhanced integration initiatives in Windsor/Essex hospitals
  - Integrated Windsor/Essex CHCs
  - Integrated Canadian Mental Health Association's (CMHA's) Kent County branch, and Sarnia/Lambton branch
  - Invested in the implementation of a coordinated dialysis transportation system in Windsor/Essex

ESC LHIN has continued to work with its established advisory networks and newly formed stakeholder groups to:

1. serve as experts in advancing clinically oriented integration opportunities
2. provide advice for a better understanding of our local health care system
3. advance planning recommendations/tactics/performance measures for health care system improvements

The following advisory networks and various key stakeholder groups/LHIN leads are available to provide advice to the ESC LHIN and monitor performance.

Networks:

- Mental Health and Addictions Advisory Network
- Rehabilitation Advisory Network
- Regional Diabetes Network
- End of Life Care/Palliative Care Network
- Ontario Renal Network
- Home First Steering Committee

Legislative and specialty-focused committees:

- French Language Health Planning Entity[3]
- Local Aboriginal Health Planning Entity[4]
- Health Professional Advisory Committee
- ESC LHIN Leadership Councils
- Primary Care Council
- Quality Council

[3] For more information on the newly formed French Language Entity, see Appendix B.

[4] Regulations for an Aboriginal Health Planning Entity have not yet been passed. To ensure regular engagement with Aboriginal communities, ESC LHIN has formed a Local Aboriginal Health Committee (LAHC), which meets bi-monthly.

Key stakeholder groups (including, but not limited to):

- Local nurse practitioners
- Local physicians
- Family health teams and community health centres
- Long-term care leadership forums
- Hospital Chief Executive Officers (CEOs) and Chief Nursing Executives (CNEs)
- Hospital Chiefs of Staff
- Health care staff

ESC LHIN Leads (expert advisors):

- Dr. Eli Malus, Critical Care Lead
- Dr. David Ng, Emergency Department Lead
- Dr. Martin Lees, Primary Care Lead
- Dr. Paul Audet, eHealth Lead

The strategic directions outlined in the initial IHSP and in IHSP 2 shaped the activities of ESC LHIN during its first six years. These directions became the foundation for our examination of funding initiatives, enhancements, fiscal recoveries, and service coordination/integration. Erie St. Clair LHIN strived to remain strategic in its activities through the development of the above-noted networks, task-oriented committees, Leads, and governance advisory bodies, which guided the receipt of focused feedback and advanced action-oriented initiatives.

Tactically, ESC LHIN examines health care service delivery on a county-by-county basis in order to:

- Understand the nature of the demand, supply, and distribution of services
- Focus on areas of greatest need and address regional disparities
- Understand and address the needs of high-risk populations
- Understand unique geographic characteristics and the impact of geography on core service delivery and outcomes
- Consider known barriers and challenges
- Consider the availability of resources
- Partner with other interested organizations to advance improvements

Table 3 outlines initiatives that were supported in 2012 through urgent priorities funding.

Table 3: ESC LHIN Initiatives, 2012

INITIATIVE	ORGANIZATION	FUNDING
Consolidated Health Information Services Project Management Office Support	Chatham-Kent Health Alliance	$50,000
Leamington Court Transportation	South Essex Community Council	$20,000
ALSO Assisted Living Southwestern Ontario	Association for People with Physical Disabilities	$367,000
Psychiatric Assessment Team	Hôtel-Dieu Grace Hospital	$360,000
ESC LHIN Home First Implementation Team	Erie St. Clair Community Care Access Centre	$300,000
Windsor Essex Community Health Centre Capital Project - Year One	Windsor Essex Community Health Centre	$257,000
Mental Health Patient Assistance Program	Canadian Mental Health & Addictions - Windsor/Essex	$80,000
Rehabilitation Network request for LHINwide work	Windsor Regional Hospital	$60,000
Mental Health & Addictions Network request for LHINwide work	Windsor Regional Hospital	$65,000
Feasability Study	St. Andrews Residence	$50,000
Emergency Department Case Manager Windsor/Essex	Canadian Mental Health & Addictions - Windsor/Essex	$84,000
Asthma Education Clinic	Windsor Regional Hospital	$30,000
Emergency Roof Replacement	House of Sophrosyne	$52,772
Clinical Lead Administrative Support	Hôtel-Dieu Grace Hospital	$35,000
Medworxx	Windsor Regional Hospital	$21,580
Long-Term Care Promotional Packages	Erie St. Clair Community Care Access Centre	$100,000
Procure Internal Audit	Windsor Regional Hospital	$25,000
Convalescent Care Beds - Rose Garden Villa	Revera Homes - Rose Garden Villa	$26,500
Patient Referral Program	Mental Health Connections	$20,000
Enhanced South Essex Transit Program	South Essex Community Council	$10,000
Operating Pressures	Canadian Mental Health & Addictions - Windsor/Essex	$58,420
Lead Administrative Support	Hôtel-Dieu Grace Hospital	$140,000
Rehab Bed Expansions	Windsor Regional Hospital	$115,700
Operating Pressures	Erie St. Clair Community Care Access Centre	$199,800
TOTAL		**$2,527,772**

Achieving New Expectations: IHSP 3

The development of IHSP 3 was informed by a number of planning frameworks (see Appendix C), guidelines, and tools. The plan also builds on previous work completed over the past six years. Moving forward with the implementation of the directions and tactics identified in IHSP 3, we have incorporated the following key considerations in our work:

1. Embed quality improvement and learning strategies into our activities
2. Advance strategies related to the collective LHIN system-wide imperatives
3. Continue to implement a consistent and transparent approach to planning, priority setting, and decision-making
4. Continue to identify, advance, and measure performance indicators and targets that support the achievement of provincial and LHIN-level goals and priorities
5. Apply a variety of communication and engagement strategies, to ensure that interested parties have an opportunity to participate in decision-making
6. Align our tactics with the impact of funding reform

In developing IHSP 3, ESC LHIN also considered the quality improvement and learning strategies outlined in HQO's *2012 Report on Ontario's Health System* (March 2012). The report's key messages include the acknowledgment that Ontario's health care system must consistently adopt evidence-based practices that can improve outcomes, eliminate waste in the system, and organize the delivery of health care around the patient to create a smooth journey for the individual. The report describes how the different parts of the system (primary care, home care, LTC, and hospitals) perform across nine dimensions of quality: accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated, and focused on population health.

The report's key findings indicate that, in all areas, progress is slow and needs to be accelerated, especially in three main areas:

1. Chronic disease management and avoidable hospitalizations
2. Wait times
3. Hospital safety

Finally, the report indicates that the most important factors in achieving the high-quality health care that Ontarians want are excellent leadership and accountability for quality and safety.

Over the past year, significant work was completed by the collective LHIN CEOs' group to advance health care system-wide LHIN imperatives. This work culminated in a vision document called *Continuing the Conversation* (April 2012; see Table 4). Four main imperatives were put forward in the report:

1. Leading with Quality & Safety
2. Enhancing Access to Primary Care
3. Enhancing Coordination & Transitions of Care for Targeted Populations
4. Holding the Gains

The aim of the LHIN CEOs in advancing these imperatives is to ensure that a standardized approach to improving patient outcomes province-wide is initiated and sustainable over time.

Table 4: *Continuing the Conversation* — Imperatives and Context

Imperatives	Context
Leading with Quality & Safety	1. The LHIN CEOs embrace the Triple Aim goals articulated by the Institute for Healthcare improvement (IHI) and the Quality and Safety Framework defined by HQO. 2. LHINs will lead efforts to drive quality and safety, identifying system-wide indicators that will be embedded into accountability agreements and will define system-wide initiatives aimed at raising quality across the province.
Enhancing Access to Primary Care	1. The LHIN CEOs have developed a strategy paper on primary care, calling for a province-wide plan to develop patient care hubs that will strengthen primary care within local neighbourhoods and communities. 2. The CEO strategy builds on the evidence that clearly shows that sustainable system models start with a strong foundation of primary health/family health care that enables access to a core set of community-based services to support people's care needs as close to their homes as possible. 3. In addition, LHINs are systematically engaging stakeholders in discussions to identify local issues and local solutions.
Enhancing Coordination & Transitions of Care for Targeted Populations	1. The LHIN CEOs know that navigating the health system and coordinating care can be challenging for certain populations who either have complex needs, access care from multiple providers, or are disadvantaged/marginalized and struggle to get the care they need, when and where they need it. 2. All LHINs endorse a system-wide focus on understanding and addressing access barriers for populations most at risk within each LHIN, and working with HSPs to build capacity within local communities to ensure sustainable solutions are achieved.
Holding the Gains	1. Under LHIN leadership, and in partnership with MOHLTC, the system has systematically identified key issues related to quality of care and implemented province-wide, coordinated responses to critical initiatives. 2. The LHIN CEOs are committed to ensuring that gains made previously are maintained as new imperatives are pursued.

Over the course of the development of IHSP 3, ESC LHIN worked to implement a consistent and transparent approach to planning, priority setting, and decision-making. We actively sought advice through our community engagement initiatives (see Table 5 and Appendix D). Across Ontario, the LHINs continue to recognize that accountability and transparency are key to defining local health care priorities. The LHINs have also been proactively disclosing information (e.g., on LHIN operations, health system plans/successes, and board documentation), as a way of demonstrating transparency and commitment to accountability within the communities served.

A priority consideration in the advancement of IHSP 3 is to work in concert with our community partners (the public, LHIN-funded and non-LHIN-funded health service providers, primary care, etc.) to make the health care system more person-centred and responsive to local needs. Community engagement refers to the methods that LHINs and health service providers undertake as they interact, share, and gather information from and with their stakeholders. Community engagement is a LHIN requirement under the *Local Health System Integration Act, 2006* (LHSIA).

Community Engagement

Community engagement informs, educates, consults, involves, and empowers stakeholders in health care or health service planning and decision-making processes to improve the health care system. In support of IHSP 3, ESC LHIN initiated a community engagement process that focused on the following key objectives:

- Identify priority populations of high users of health care services and/or specific geographies affecting outcomes in the four strategic directions of IHSP 3
- Obtain input and information on developing and implementing tactics for improving health care for targeted populations for each of IHSP 3's strategic directions
- Obtain input and information on issues and barriers to consider when implementing these tactics
- Obtain input and information on performance measures and targets for gauging ESC LHIN's success in improving outcomes vis-à-vis the four strategic directions

Table 5 outlines the community-engagement activities undertaken to establish IHSP 3 priorities and develop the proposed action plan, as well as the participants involved in the process. For specific input received across various stakeholder groups from activities conducted in November and December 2012, see Appendix J.

Table 5: IHSP 3 Community-Engagement Strategies

Method	Description	Participants Engaged
Network planning sessions	Planning meetings over a six-month period with ESC LHIN advisory networks to: a) Update and confirm priority population utilization trends and data b) Advance tactical directions intended to move the overall strategic aims of the plan c) Identify key performance indicators for specific areas/populations d) Set and confirm performance improvement targets for specific areas (covering one to three years)	- End-of-life care - Mental health and addictions - Diabetes (Diabetes Regional Coordination Centre LHIN Advisory Network) - Rehab - ED/ALC
Stakeholder survey	Survey issued broadly to health service providers and stakeholders and focused on a) Confirming and prioritizing target populations b) Receiving suggested tactics to address outcome for those populations	- Home First geographic teams - Family health teams/nurse practitioner-led teams - ED physicians (via ED chiefs) - Hospital Chief of Staff/Chief Nursing Executives
Key informant interviews/focus groups	Interviews/focus groups with targeted stakeholders to receive feedback on: a) Suggestions on tactics for improving health care for targeted populations b) Issues and barriers to consider for implementing these tactics c) How to establish and confirm performance measures that are reasonable, achievable, and targeted to the overarching ESC LHIN *Ministry-LHIN Performance Agreement* (MLPA) indicators	- Local Aboriginal Health Committee - French Language Health Planning Entity - Primary Care Council - Public health officials
Leadership Council round tables	Round table meetings with Leadership Council members to: a) Confirm tactics for improving health care for targeted populations b) Receive feedback on issues and barriers to consider for implementing these tactics c) Establish and confirm performance measures that are reasonable, achievable, and targeted to the overarching ESC LHIN MLPA indicators	- Governance and executive leaders of LHIN-funded agencies

Health System Performance

The LHINs also continue to identify, advance, and measure health system performance indicators and targets that support the achievement of provincial and LHIN-level goals and priorities (see Table 6 and Section 7: Conclusion and Next Steps). To support this direction, a LHIN Health System Performance Indicator Framework was developed as a tool to help LHINs identify indicators to monitor the performance of their health service providers (HSPs). As a tactical and operational tool, the goal of the framework is to allow LHINs and HSPs to work together to identify and monitor indicators that support the achievement of provincial priorities, by focusing on the components of and enablers to the delivery of quality health care services (across the continuum of care) to Ontarians. The framework is designed to support organizational and system performance measurement, guided by the strategic areas of focus for the LHIN, and encourage health care providers to work together in support of improved outcomes and experiences.

Review of ESC LHIN Performance Gains for 2011–12

Table 6 outlines the level of achievement reached on key performance indicators in ESC LHIN during fiscal year 2011–12.

Table 6: Key Performance Indicators, ESC LHIN, 2011–12

PERFORMANCE INDICATORS	BASELINE FISCAL YEAR 2010-11	LHIN 11-12 STARTING POINT	LHIN 11-12 PERFORMANCE TARGET	MOST RECENT 2011-12 LHIN PERFORMANCE	% FROM TARGET FOR MOST RECENT QUARTER
Top provincial performances were achieved on many LHIN performance indicators. Although there is still work to do in achieving these targets, for many months the ESC LHIN led the province in ED wait times for complex non-admitted patients, as well as wait times for MRIs, cancer surgery and cataract surgery. The ESC LHIN has been successful at impacting many of the indicators with Aging-at-Home funding, Urgent Priority funding, Wait Times funding and in-year reallocations. LEAN management processes have also improved efficiency within health service providers.					
90th Percentile Wait Times for Cancer Surgery (in days)	45	48	45	39	-13.3%*
ESC LHIN continues to work closely with the Windsor Regional Cancer Centre, which is a high Ontario performer.					
90th Percentile Wait Times for Cardiac Surgery (in days)	NA	NA	NA	NA	NA
This service is not available within the ESC LHIN. The area's residents typically access this care in the South West LHIN.					
90th Percentile Wait Times for Cataract Surgery (in days)	64	56	56	63	12.5%
Hôtel-Dieu Grace Hospital continues to be recognized as a top provincial performer for cataract surgery wait times due to its circular flow and LEAN processes. This model has been used at other hospitals throughout the ESC LHIN to improve efficiency.					
90th Percentile Wait Times for Hip Replacement (in days)	121	132	121	160	32.2%
The ESC LHIN continues to meet provincial targets for hip replacements. Collaboration continues between physicians and hospital staff to improve scheduling and reduce wait times for these surgeries.					
90th Percentile Wait Times for Knee Replacement (in days)	130	142	130	176	35.4%
The ESC LHIN continues to meet provincial targets for knee replacements. Collaboration continues between physicians and hospital staff to improve scheduling and reduce wait times for these surgeries.					
90th Percentile Wait Times for Diagnostic MRI Scan (in days)	59	70	28	42	50%
ESC LHIN is a top provincial performer for MRI wait times. LEAN initiatives have maximized efficiency of the area's MRIs. Both BWH and WRH held the best MRI wait times this year. Additional operating hours were funded by the Wait Times Office, further supporting wait-time reduction.					
90th Percentile Wait Times for Diagnostic CT Scan (in days)	28	26	26	19	-26.9%
Rapid booking processes, additional scan time and ensuring standardized prioritization of cases has reduced wait times and achieved targets.					

PERFORMANCE INDICATORS	BASELINE FISCAL YEAR 2010-11	LHIN 11-12 STARTING POINT	LHIN 11-12 PERFORMANCE TARGET	MOST RECENT 2011-12 LHIN PERFORMANCE	% FROM TARGET FOR MOST RECENT QUARTER
Percentage of Alternate Level of Care (ALC) Days	13.24%	10.85%	12%	12.06%	.5%

The following pressures impacted ALC performance in Windsor/Essex:

- Closing of one long-term care (LTC) home and resulting overlap in transitioning residents into their new home
- Major flooding of Banwell Gardens LTC home causing emergency relocation of residents
- Delays in construction of a new LTC home

ALC rates in Chatham-Kent and Sarnia/Lambton remained stable in 2010-2011.

Assess and Restore programs at Hôtel-Dieu Grace Hospital, Leamington District Memorial Hospital and Chatham-Kent Health Alliance, CCAC resettlement services, assistive living expansions and activation teams have improved ALC performance and decreased hospital length of stay.

End-of-Life Outreach teams have supported people in their wish to die at home, in the comfort of their own surroundings. Additionally, Geriatric Emergency Management (GEM) nurses and CCAC case managers in emergency departments have also been successful at linking patients to appropriate community services.

Additional strategies included:

- Opening 60 new interim LTC beds at Leamington Court Retirement Home
- Funding for 20 new complex continuing care beds at Windsor Regional Hospital
- Purchase and implementation of Medworxx Clinical Utilization tool to better manage patient flow with real-time data
- Geriatric Mental Health Outreach Teams focused on patients with dementia
- Increased use of transitional care programing
- Conversion of underused LTC respite beds into long-stay beds
- ESC LHIN Rehabilitation Strategic Plan
- Process Improvement Plan University
- Daily hospital discharge bullet rounds
- Primary Care Engagement/Primary Care Lead

The ESC LHIN continues to look for sustainable solutions to ALC consistent with a Home First philosophy.

90th Percentile ER Length of Stay for Admitted Patients (in hours)	23.32	18.5	17	25.08	47.5%

A rise in ALC lengthened the ED wait times for admitted patients for whom beds were not immediately available. Pay-for-Performance funding and ED Performance Improvement Plans resulted in more CT scan time for the ED, hiring of flow coordinators, ED Admissions Teams, registration improvements and increased triage nursing.

90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS** I-III) Patients (in hours)	7.13	6.8	6.5	7.25	11.5%

As bed pressures developed in Windsor/Essex, monitoring of non-admitted complex patients also increased. To assist in lessening the impact from bed pressures, the following were implemented:

- flow coordinators
- nurse practitioners
- physician assistants
- increased ultrasound time
- creation of a medical admissions unit
- registration improvement initiatives
- increased triage nursing

90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS** IV-V) Patients (in hours)	4.32	4.3	4	4.1	2.5%

ED Pay-for-Results funding and ED Performance Improvement Plans helped create fast-track areas, while nurse practitioners and flow nurses were effective at managing low-acuity, non-admitted patients in emergency departments.

Repeated Unplanned Emergency Visits within 30 Days for Mental Conditions***	16.45%	14.5%	18.8%	19.73%	5%

A review of patient charts was undertaken to better assess the needs of the moderately mentally ill. Also, high-risk youth who frequent the ED are being assessed through a joint initiative between the Ministry of Child and Youth Services and the ESC LHIN.

PERFORMANCE INDICATORS	BASELINE FISCAL YEAR 2010-11	LHIN 11-12 STARTING POINT	LHIN 11-12 PERFORMANCE TARGET	MOST RECENT 2011-12 LHIN PERFORMANCE	% FROM TARGET FOR MOST RECENT QUARTER
Repeated Unplanned Emergency Visits within 30 Days for Substance Conditions***	19.16%	19%	17.2%	22%	27.9%
To reduce ED visits, addiction-care providers were trained in overdose prevention. Residential treatment programs were improved with the addition of withdrawal management services, as well as psychiatric assessments.					
90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)**	N/A	23%	23%	19%	-17.4%*
Readmission within 30 Days for Selected Case Mix Groupings ***	15.31%	15%	12.8%	13.55%	5.9%

The Erie St. Clair region has one of the highest levels of chronic disease, particularly COPD and cardiovascular conditions. To improve management of these conditions, promotion of the Health Care Connect program has been effective in linking over 5,000 patients with a family doctor or nurse practitioner.

Rapid Response Chronic Disease Management Teams have been developed to provide care to COPD patients and there are plans to expand this care to congestive heart failure patients. Rehab services were also provided by outreach teams as a part of this program.

The Chatham-Kent Community Health Centres are expanding their Rapid Response Chronic Disease Management Team to Wallaceburg and Walpole Island to provide stronger chronic disease management and increased primary care for these communities.

GEM nurses provide linkages to these programs directly from emergency departments, and nurse-led outreach teams in long-term care homes are helping to decrease readmissions for these chronic diseases.

* A negative percentage means that the target has been met.
** Canadian Triage and Acuity Scale.
*** FY 2011–12 is based on 75 per cent of the data (Q2 to Q4), due to availability.

For the 2013–16 timeframe, the overall direction of ESC LHIN IHSP 3 will continue to be action-focused and results-based, and to build on previous work. The four confirmed IHSP 3 strategic directions for the next three years are:

1. Improved outcomes in alternate level of care
2. Improved outcomes in emergency department care
3. Improved outcomes in chronic disease management
4. Improved outcomes in mental health and addictions

These elements are covered in more detail in Section 6: Priorities and Strategic Directions for the Local Health Care System. Erie St. Clair LHIN will use 90-day review cycles to monitor progress and ensure that established targets are met and adjustments made as required. An ESC LHIN scorecard will be developed for ongoing reporting purposes, and will focus on three key areas:

1. Outcome indicators — patient improvements (e.g., mortality indices, lower length of stay, discharge destinations)
2. Process indicators — operational improvements (e.g., quicker access to care, time to assessment)
3. Balancing indicators — key health system improvements (e.g., reduced repeat visits to the ED, improved care transitions, lower ALC length of stay)

Section 3: Provincial Context and Priorities

Section 3 summarizes current MOHLTC priorities and the LHINs' health system imperatives, in order to illustrate how they set the context for IHSP 3.

Provincial Context

Supporting the delivery of health care in a challenging environment and mandate for transformation, Ontario's LHINs are responsible for the allocation of about half of the province's health care expenditures, or about $22 billion in funding as of 2011 (estimates 2011–12). Working with MOHLTC, LHINs will ensure that local and regional plans align with provincial priorities for the health care system to improve access to care and ensure sustainability.

Between 2003–04 and 2011–12, health sector funding in the provincial budget increased at an average rate of 6.1% annually, for a total increase of $17.9 billion. However, the province now faces substantial fiscal pressures. In an effort to reduce expenditure growth to ensure sustainability and manage those challenges, the government has stated that "funding for the health care system cannot continue to grow at past rates."[5] This will require getting better value for money from all parts of the health care system to maintain access to services and continue to improve the quality of care.

Ontario's Action Plan for Health Care indicates that a key driver of future health care costs (in addition to general inflation and changes in technology) and a factor in the sustainability of the system is the observation that the population of Ontario is getting older, and as people age they require more health care. Specifically, in 10 years there will be 43% more seniors in the province than there are now and in 20 years there will be twice as many. The *Action Plan* further found that without changing how we deliver care in Ontario, in 20 years the health care system would cost $24 billion more per year than it does now. Therefore, Ontario's LHINs are planning for changes to the health care system that support delivering the right care in the right place, promote value for the dollar, and ensure that resources are used sustainably.

Ontario's LHINs, with a mandate to engage with the public, health care providers, and other stakeholders in their local communities, are uniquely positioned to address these fiscal, demographic, and technological challenges. LHINs will develop local plans such as those outlined in IHSP 3.

With the fiscal and demographic pressures outlined above reinforcing the need to make changes now, several other important factors are currently aligned to provide broad support for the implementation of the *Action Plan*'s priorities:

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[5] 2012 Ontario Budget.

- A shared commitment among providers, administrators, and frontline staff to ensure the system is ready for the challenges of the future
- Embracing technologies in order to provide the new productivity tools and diagnostic techniques that support efficient ways of managing information
- Using the latest evidence and research to guide how resources are used, where they are most effectively used, and best serve patient needs

Provincial Priorities and LHIN System Imperatives

In January 2012, the province unveiled *Ontario's Action Plan for Health Care* to meet the challenge of managing spending growth while continuing to provide high-quality care to all Ontarians.

The *Action Plan* identifies three focus areas:

1. Keeping Ontario Healthy
2. Faster Access and a Stronger Link to Family Health Care
3. Right Care, Right Time, Right Place

Using these priorities as a guide, each LHIN can develop local priorities and areas of focus to address local needs.

To align the high-level goals of the *Action Plan* with their IHSP 3s, Ontario's LHINs have developed several system imperatives. These imperatives, highlighted below, will guide decisions LHINs make regarding the allocation of resources amongst providers and the programs and projects to be funded at the local level. Ongoing accountability will be tracked through strategic planning, accountability agreements, and performance measurement.

As each LHIN develops its IHSP 3, it will work in partnership with MOHLTC and local stakeholders to ensure a sustainable health care system that delivers high-quality care and that will be there for future generations.

The goal of the *Action Plan* is to create an "obsessively patient-centred" health care system by ensuring care is based on evidence, care is delivered in the right setting, and care is coordinated so that patients move from one provider to another seamlessly.

Keeping Ontario Healthy

This *Action Plan* priority will focus on helping people stay healthy by supporting the habits and lifestyle changes that keep people healthy. In addition to tackling childhood obesity, smoking, and cancer screening, the province will continue to work on better management of chronic conditions, such as diabetes. LHINs across Ontario have been working with local providers on chronic disease prevention and management strategies for many years, and a strong foundation is in place to build upon. There have been many measurable accomplishments improving the way diabetes patients are treated by increasing the coordination of care and adding new resources for individuals and families.

Faster Access and a Stronger Link to Primary Care

Primary care is the hub of the health care system for most people. The primary care physician or health care team is ideally the first point of contact with the health care system when someone needs help, unless it is an emergency. Outside of the hospital, it is also where follow-up care is provided, and referrals are made to more specialized professionals. *Ontario's Action Plan* identifies faster access to primary care; more ways to access family health care resources, such as telemedicine points of contact; and the introduction of quality measures to primary health care as key components of a fully integrated system. The goal is to ensure appropriate care from primary care providers, to deliver right care in the right place at the right time, and to help reduce hospital readmissions.

In alignment with the *Action Plan*, Enhancing Access to Primary Care is an imperative that will help ensure people have timely access to a primary care provider. It will also support the appropriate use of hospital and clinic resources. Guided by the *Action Plan*'s proposal to bring the organization of primary care under the mandate of the LHINs, planning for this outcome is spelled out in more detail in the IHSP, including how LHINs will measure success and how planned changes will have an impact.

In December 2012, in support of the *Action Plan*, MOHLTC released a framework titled Health Links. Health Links is a new model of health care delivery that is centred on patient care networks. In advancing this direction, MOHLTC recognized that providing the right care at the right time in the right place requires that patients and providers work together more closely than they have in the past. The network partnership created through Health Links views primary care providers as essential to transformation, whether it's taking more responsibility for keeping people well, screening them appropriately for chronic diseases, or managing their care when they are sick. It further identifies that health service providers are also essential to providing superior care. Patients also need to be part of transformation as they experience the system, and that they know better than anyone where and how the system can improve.

Essentially, all stakeholders through Health Links are being asked to be flexible in delivering services differently, in a way that best meets the needs of communities, to move and connect resources between providers, and to be accountable for improved outcomes for patients. There is consensus regarding the need for local (sub-LHIN) partnerships (or networks) that would come together to deliver improved value for money, ensure a higher quality of care, and improve access. The partnership will also allow for deeper engagement with patients and help develop a true patient-centred focus to the system.

As planning moves forward for Health Links, it is anticipated that the networks will look different in every region. The partnership will be based on a sound framework, with specific principles consistent across all networks to ensure provincial goals and outcomes are prioritized. These principles include:

1. Person-centred planning with strong mechanisms in place for the patient voice to be heard
2. Building on existing delivery organizations and leveraging current capacity and best practices
3. Representation across sectors with joint accountability for attainment of results
4. Common targets and metrics (e.g., high users of the health care system, ALC, ED wait times and use, readmission rates)
5. Evaluation built in from the beginning
6. Flexible funding, to ensure that resources are focused where they can be used to deliver results

Erie St. Clair LHIN's *Health Links Implementation Plan* will bring together providers from across the continuum of care. The initial emphasis will be on establishing partnerships amongst providers that are most essential to fulfilling the immediate primary care needs of each sub-LHIN-area target population. These partnerships will provide a starting point for launching Health Links, with the understanding that the role and basket of services will be expanded as Health Links are established and mature. The implementation plan has been divided into four phases, with the bulk of the work front-loaded into Phase 1. While there is much excitement and inertia among our partners to roll out Health Links region-wide, implementation will be a lengthy process. The length of time needed for implementation will allow us to collectively learn from our efforts and realistically approach this new endeavour, given the other priorities we all will continue to address.

Figure 1 details the process and approximate timelines for implementing Health Links in Erie St. Clair.

Figure 1: Health Links Rollout Plan, ESC LHIN

Reducing hospital readmissions will have an important effect on the sustainability of the health care system. In 2008–09, the rate for unplanned readmissions to hospital was 15% in Ontario, which MOHLTC considers high compared to other jurisdictions.[6]

LHINs, working with local providers, can help integrate the health care system more fully, developing ways to manage the planning and accountability for the full patient journey, thereby improving results for everyone. The system leadership imperative, Implementing Evidence-Based Practice to Drive Safety, will support consistent, coordinated responses to high-priority safety issues in the system. By reducing adverse events in all care settings (e.g., hospitals, long-term care, community/home), Ontario's LHINs can build on the many patient safety initiatives currently implemented by health care providers. In partnership with HQO and other key stakeholders, LHINs will work to develop coordinated plans to reduce adverse incidents that impact the quality of care, and will embrace best evidence-based decision-making.

Right Care, Right Time, Right Place

The **Right Care** means care that is informed by what the best scientific evidence and clinical guidelines have determined is the best care for patients. It eliminates unnecessary procedures and tests, making resources available for those who need them most. The province and the LHINs will work with HQO to translate evidence into tools and guidelines that can help providers put patient-centred and evidence-based care into practice.

[6] *Baker Report*, 2012.

Care at the **Right Time** means having faster access to the care patients need. This kind of care could mean telemedicine or supports to help patients stay at home longer, for example, in their communities close to their family and friends. This priority will also mean a renewed emphasis on preventative and proactive care so that chronic conditions are managed, thus reducing the number of hospitalizations a person will require and easing the strain on EDs and inpatient beds across the province.

Care in the **Right Place** addresses several serious issues in the health care system. One of the most pressing issues is the challenge arising from alternate level of care patients, who are in hospital beds but who would be best cared for in the community with support services to help maintain and improve their quality of life. Community care costs a fraction of what it costs to keep a patient in a hospital bed. To support the *Action Plan*'s goal of providing more community-based care for seniors, the 2012 provincial budget will increase funding for home and community service by 4 percent annually over the next three years.[7]

The implementation of all three priorities will require changes in how traditional health care providers in the system are funded; as well, our hospitals will see some significant changes in how we fund them, so that the system becomes more patient-centred. LHINs will work with hospital and community partners to transition procedures out of the high-cost hospital setting into non-profit community-based clinics. Further, hospitals' base budgets will be transitioned into a patient-centred funding model where the provider is rewarded for high-quality care and better use of resources. LHINs will work with hospitals to manage the plan for the phased implementation of this change, which began in April 2012. To help address the fiscal concerns of the province, hospital base budgets have been frozen and there will only be a 2 per cent increase in funding for certain activity-based initiatives, such as targeted wait-time reductions and priority treatments.

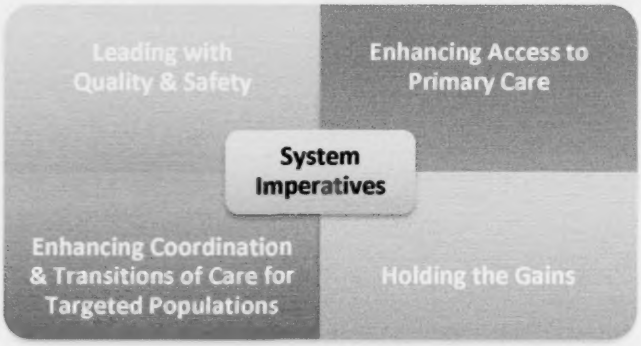
In addition, the province will launch a Seniors Strategy, building on the successes of the Aging at Home program. This will put renewed focus on keeping people from being unnecessarily admitted to hospital. The expansion of community-based care and the call to empower LHINs to shift resources to where the need is greatest will be based on local needs and plans developed throughout this IHSP.

Local Health Integration Networks also have a mandate under this plan to further integrate the health care system, which will enable Ontario residents to more easily navigate care and to access programs and services in a seamless manner. Enhancing Coordination and Transitions of Care is a LHIN system imperative that focuses on key populations of "high-needs" patients and those at risk of becoming high-needs patients. The health care system will provide coordinated plans of care for these targeted populations to assist them to get the right care when and where they need it.

[7] 2012 Ontario Budget.

As outlined above, three of the LHIN's strategic system imperatives easily coordinate with the *Action Plan*'s three priorities, thus providing local guidance for the *Action Plan*'s provincial vision. A fourth LHIN system imperative, Holding the Gains, will help Ontario's LHINs make sound choices about local projects by ensuring that achievements made to date are not lost as new priorities are developed and moved forward. This will present a challenge for all organizations that periodically refresh their strategic directions, and LHINs must be sure to protect the many advances they have made in improving wait times, value for money, transparency, and accountability. Figure 2 outlines the LHIN system imperatives.

Figure 2: LHIN System Imperatives Map


Leading with Quality & Safety
Enhancing Access to Primary Care
System Imperatives
Enhancing Coordination & Transitions of Care for Targeted Populations
Holding the Gains

IHSP 3 Provincial Priorities, LHIN System Imperatives, and the IHSP

Since 2005, LHINs have been accountable to their local communities to plan and integrate the health care system, in partnership with MOHLTC. Throughout this IHSP, there is close alignment with *Ontario's Action Plan* and the provincial budget to transform the health care system in Ontario.

The system imperatives developed by Ontario's LHINs will help guide the development of priorities that reflect the high-level goals of the *Action Plan*.

LHINs are committed to achieving a balance of the province's goals in the *Action Plan,* coordinated within the LHIN's strategic imperatives and reflecting the needs of our local communities and regions. In this IHSP, they come together in a series of priorities that balance the input of our health care provider partners and all key stakeholders (for more information on provincial activities refer to Appendix E: Local Health Integration Network (LHIN) Provincial Framework for Planning).

Section 4: ESC LHIN's Vision for the Local Health Care System

Vision

The Erie St. Clair Local Health Integration Network's (ESC LHIN's) vision is: *Better Care, Better Experiences, Better Value.*

Principles

The Integrated Health Service Planning Framework (2013–16) has attempted to advance a standard set of principles and values to be used by all 14 LHINs in preparing their IHSPs. This work builds on the preamble of the *Local Health System Integration Act, 2006* (LHSIA), and is better tailored to meeting the ongoing changes associated with IHSP advancement and implementation over time. These principles are as follows:

Relevance: Decisions should be based on reasons (i.e., evidence, principles, values, and arguments) that fair-minded people can agree are relevant under the circumstances.

Publicity: Decision processes should be transparent and decision rationales should be publicly accessible.

Revision: There should be opportunities to revisit and revise decisions in light of further evidence or arguments, and there should be a mechanism for resolving disputes.

Empowerment: There should be efforts to optimize effective opportunities for participation in priority setting and to minimize power differences in the decision-making context.

Consistency: There should be consistent elements of priority-setting and decision-making frameworks used by the LHINs. This includes common key domains and criteria with common definitions for the criteria as a starting point for the LHINs.

Refinement: LHINs should be able to modify their decision tools by modifying criteria to reflect local priorities.

Transparency: The transparency of the decision-making process to the impacted stakeholders (i.e., health service provider organizations) should be maintained at all times, even though timelines may affect the level of engagement.

Enforcement: There should be a leadership commitment to ensuring that the first seven principles are considered.

Values

Equity: Mitigating impact on the health status and/or access to service of recognized sub-populations where there is a known health status gap between this specific population and the general population.

Efficiency: Extent to which a program/initiative contributes to the efficient utilization of health services and financial and human resources capacity in order to optimize health and other benefits within the system.

Client-Focused: Extent to which a program/initiative meets the health needs of a defined population and the degree to which patients/clients have a say in the type and delivery of care.

Innovation: Impact on the generation, transfer, and/or application of new knowledge to solve health or health system problems; encouraging leading practices and innovation; and building on evidence and the application of leading practices.

Partnerships: Degree to which appropriate levels of partnership and/or appropriateness of partnerships (both LHIN funded and non-LHIN funded) will be achieved in order to ensure service-quality enhancement, improved comprehensiveness, optimal resource use, minimal duplication, and/or increased coordination.

Community Engagement: Level of involvement of targeted population and other key stakeholders in defining the project and planned involvement in evaluating its impact on population health and key system performance.

Developing the IHSP

The IHSP is defined in LHSIA as the local strategic plan intended to integrate the local health system. Erie St. Clair LHIN's IHSP 3 is the public presentation of our vision, priorities, and strategies, and the implementation plan for the three-year period beginning in April 2013. IHSP 3 establishes the building blocks for success and communicates the priority areas that will guide our LHIN's activities over the next three years. IHSP 3 also demonstrates our approach to integrated planning for the local health system.

Community engagement, along with demographic and population health status data analyses and health system use and performance data analyses, forms the basis from which ESC LHIN created IHSP 3. By understanding relationships and needs in the region, and by listening to the community, we identified important local issues. An understanding of the complex relationships and circumstances within our local health care system helped provide us with a clear rationale for our plans and proposed actions.

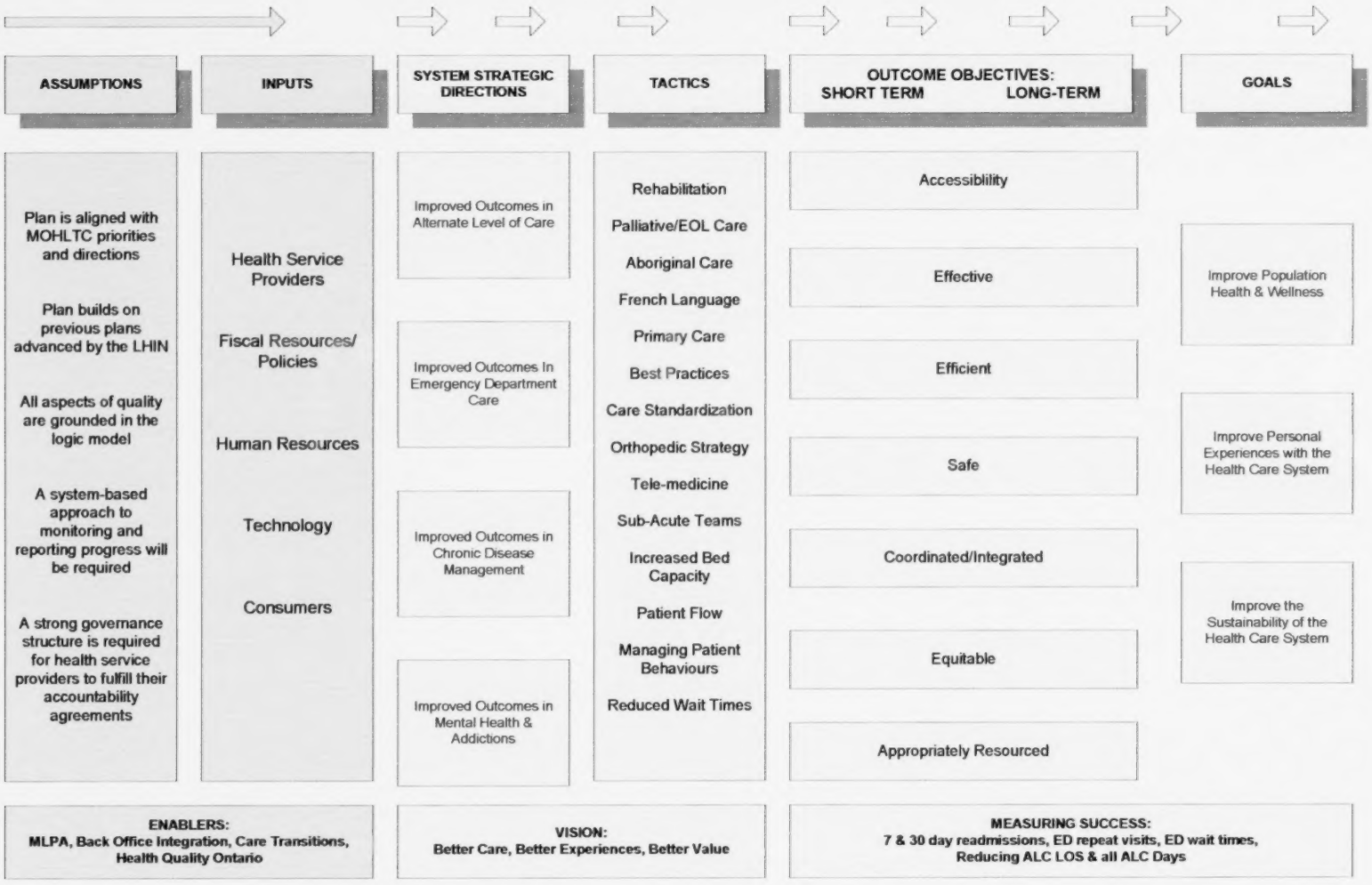
Erie St. Clair LHIN's IHSP 3 is the cornerstone on which ESC LHIN decisions and plans will be built over the coming three-year period. Although components of the plan may change, the analysis we performed during its development provides direction for ESC LHIN's activities. It includes measurable targets, such as those outlined in the MLPA, so that we can monitor and report on our success to the community.

Erie St. Clair LHIN's IHSP 3 also communicates key integration opportunities and local priorities for health system integration. Erie St. Clair LHIN supports and actively encourages integration as opportunities arise. Priorities for integration are aligned with *Ontario's Action Plan*.

Erie St. Clair LHIN will work with MOHLTC to ensure that we are achieving both provincial and local goals and objectives. *Ontario's Action Plan* and the LHIN CEO's strategic vision document, *Continuing the Conversation,* set out the high-level direction for Ontario's health care system. Through IHSP 3, ESC LHIN lays out how we are guided by *Ontario's Action Plan* via specific goals for our communities.

Priorities and strategies developed by ESC LHIN recognize resource constraints and plan within a defined funding envelope. Our IHSP 3 considers analyses of local resources issues and opportunities for development on a variety of strategic areas. Figure 3 illustrates the various components of IHSP 3, giving a bird's-eye view of the plan.

Figure 3: IHSP Logic Model



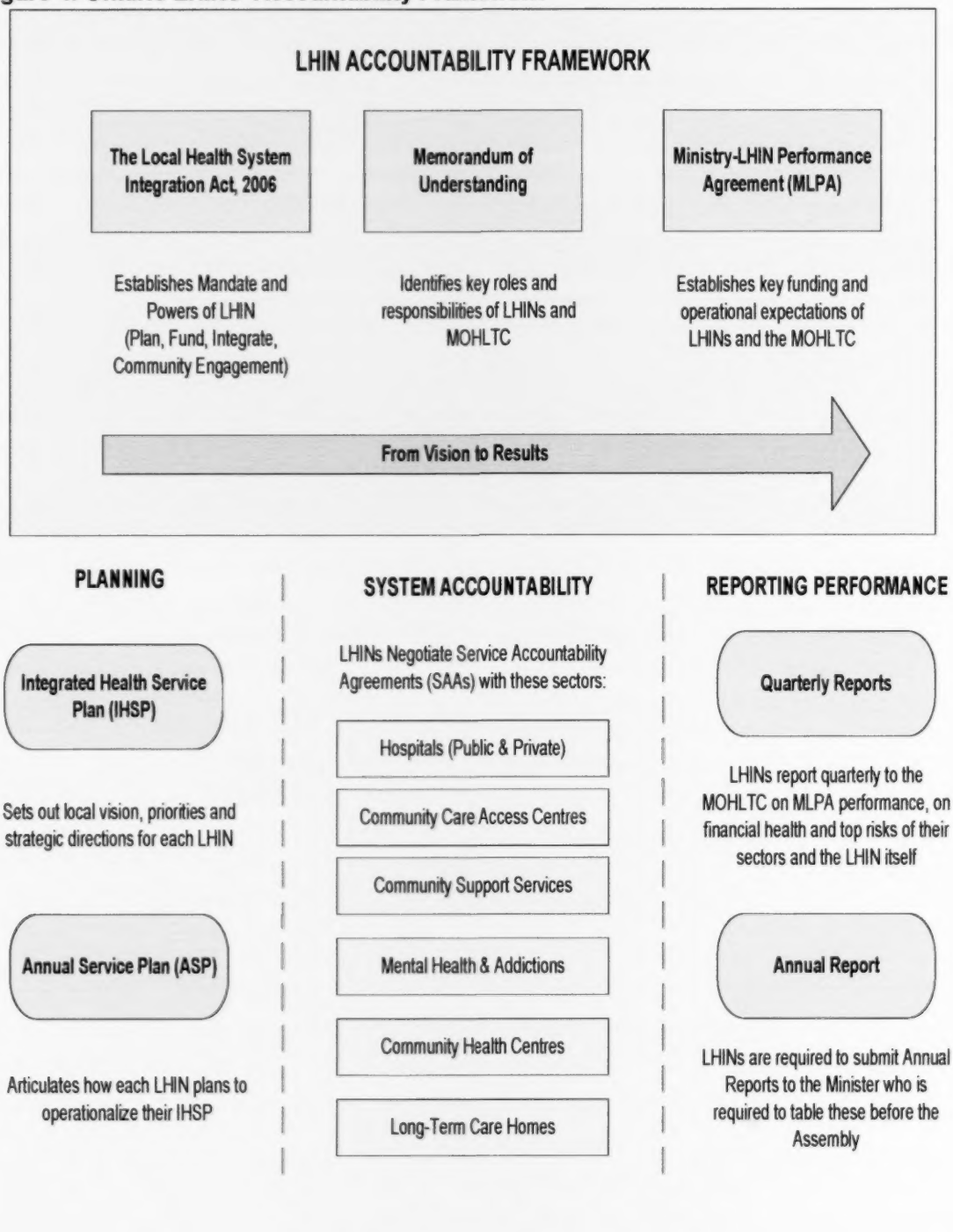
Provincial Context

Erie St. Clair LHIN's IHSP 3 is one of several plans, agreements, and actions that together make up the provincial planning cycle, including the activities not only of the LHINs themselves, but of government agencies and health service providers (refer to figure 4). These include:

- **Accountability agreements** — both between MOHLTC and the LHINs, and between the LHINs and health service providers
- **Annual planning submissions** — by the health service providers to the LHINs, and from the LHINs to MOHLTC
- **Results-based planning (RBP)** — the Ontario government's budgeting and planning cycle has multiple milestones for gathering information and reporting to the public
- ***Ontario's Action Plan for Health Care*** — MOHLTC's plan to build a quality system that is more responsive to patients and delivers better value for taxpayers

The Ministry of Health and Long-Term Care follows an annual planning cycle. Each LHIN also has a planning process, as does each health service provider. *Ontario's Action Plan* is intended to drive and align other planning activities in the system, and defines the priorities for the LHINs' IHSPs.

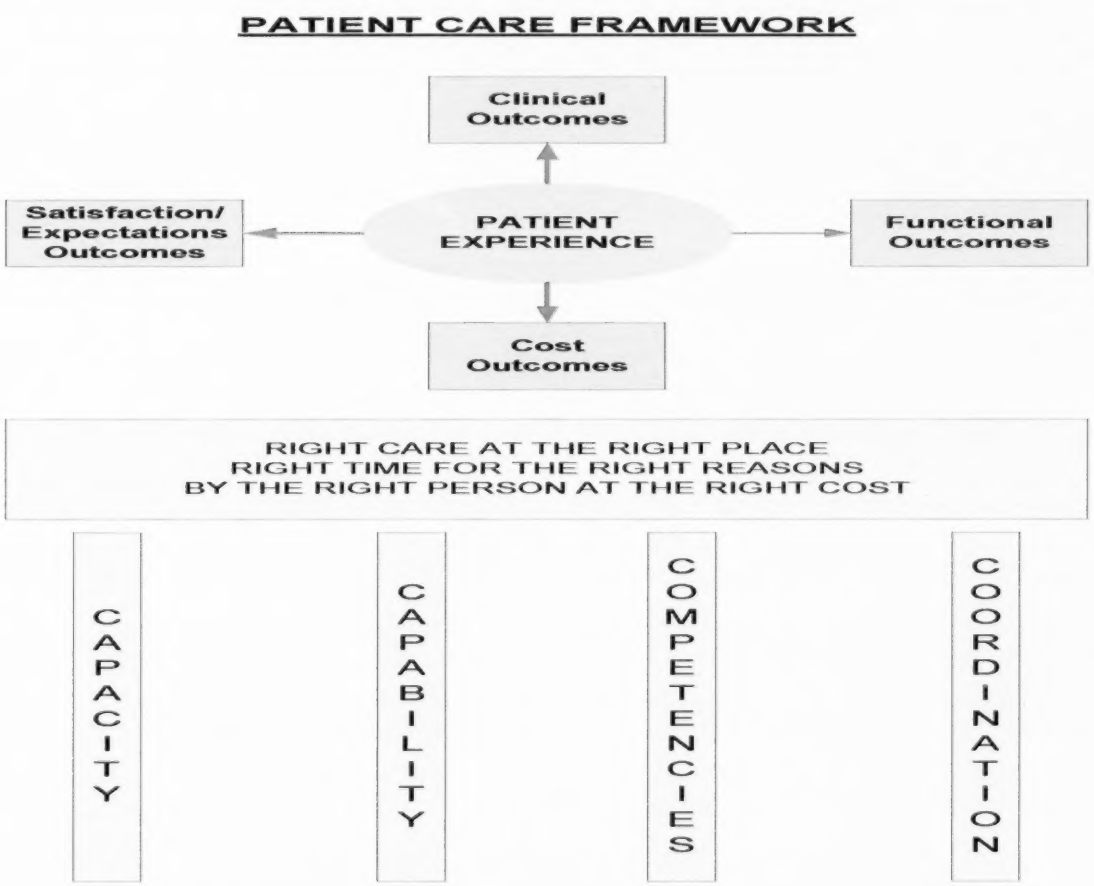
Figure 4: Ontario LHINs' Accountability Framework


LHIN ACCOUNTABILITY FRAMEWORK
The Local Health System Integration Act, 2006
Memorandum of Understanding
Ministry-LHIN Performance Agreement (MLPA)
Establishes Mandate and Powers of LHIN (Plan, Fund, Integrate, Community Engagement)
Identifies key roles and responsibilities of LHINs and MOHLTC
Establishes key funding and operational expectations of LHINs and the MOHLTC
From Vision to Results
PLANNING
Integrated Health Service Plan (IHSP)
Sets out local vision, priorities and strategic directions for each LHIN
Annual Service Plan (ASP)
Articulates how each LHIN plans to operationalize their IHSP
SYSTEM ACCOUNTABILITY
LHINs Negotiate Service Accountability Agreements (SAAs) with these sectors:
Hospitals (Public & Private)
Community Care Access Centres
Community Support Services
Mental Health & Addictions
Community Health Centres
Long-Term Care Homes
REPORTING PERFORMANCE
Quarterly Reports
LHINs report quarterly to the MOHLTC on MLPA performance, on financial health and top risks of their sectors and the LHIN itself
Annual Report
LHINs are required to submit Annual Reports to the Minister who is required to table these before the Assembly

Local Context

Figure 5 illustrates the patient care framework that is used by ESC LHIN when looking to address gaps and create needed improvements in local health care service and care provision. The framework is built on a clinical value compass approach, so named to reflect its similarity to a directional compass. It has four cardinal points: (1) functional status, risk status, and well-being; (2) costs; (3) satisfaction with health care and perceived benefit; and (4) clinical outcomes.

Figure 5: ESC LHIN Patient Care Framework



The patient care framework illustrates that, in order to manage and improve the value of health care services, providers will need to measure the value of care for similar patient populations, analyze the internal delivery processes, run tests of changed delivery processes, and determine if these changes lead to better outcomes and lower costs. Fundamental to this model is the understanding that the process of measurement should be intertwined with the process of care delivery so that front-line providers are involved in both managing the patient and measuring the process and related outcomes and costs.

The main aim of this framework is the provision, through the system's processes, of the "right care at the right place at the right time for the right reasons by the right person at the right cost":

- The **right care** refers to services that bring appropriate resources and skills to the management of the patient's specific health needs
- The **right place** is a facility that has the capability to provide services of the complexity required to meet patients' health needs
- The **right time** means having access to services within a timeframe that minimizes adverse consequences and potential complications

In order to achieve these aims, four key pillars of support must be effectively addressed: capacity, capability, competence, and coordination. If any of these areas are underdeveloped or omitted, the risk is substantial for system failure and/or the inability to positively change patient outcomes. For the purposes of this patient care framework/model, the following definitions apply:

Capacity

Capacity in health care has evolved to become capacity building, which is the creation of an enabling environment with appropriate policy and legal frameworks, institutional development, and health human resources in which all stakeholders participate.

Capability

Conceptually, health capability enables us to understand the conditions that facilitate and the barriers that impede health, and the ability to make health choices. In an applied sense, capability refers to the minimum support services, technology, equipment, staffing, and safety standards required in health facilities to ensure the provision of safe and appropriately supported clinical services.

Competencies

In a general context, competence is the state or condition of being sufficiently qualified to perform a particular action. To achieve this, the health care provider must possess the proper knowledge, skills, training, and professionalism. In a professional practice context, competencies are an important consideration, referring to the ability of the provider to administer safe and reliable care on a consistent basis.

Coordination

Coordination can be viewed from three unique perspectives within the health care realm:

- **Patient/family perspective**: Care coordination is any activity that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.

- **Health care professional perspective**: Care coordination is a patient- and family-centred, team-based activity designed to assess and meet the needs of patients while helping them navigate effectively and efficiently through the health care system. Clinical coordination involves determining where to send the patient next (i.e., sequencing among specialists), what information about the patient is necessary to transfer among health care entities, and how accountability and responsibility are managed among all health care professionals (doctors, nurses, social workers, care managers, supporting staff, etc.). Care coordination addresses potential gaps in meeting patients' inter-related medical, social, developmental, behavioural, educational, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes, according to patient preferences.

- **System perspective**: Care coordination is the responsibility of any system of care to deliberately integrate personnel, information, and other resources needed to carry out all required patient care activities between and among care participants (including the patient and informal caregivers). The goal of care coordination is to facilitate the appropriate and efficient delivery of health care services both within and across systems.

Section 5: Overview of the Erie St. Clair Health Care System

This section provides an overview of the Erie St. Clair local health system, including information on the populations served, their health status, and health behaviours. It concludes with an explanation of the many factors that affect the health of the Erie St. Clair population. Where possible, the analysis includes a comparison of the following planning areas: Chatham-Kent, Windsor/Essex, Sarnia/Lambton, ESC LHIN, and the province of Ontario. This information is widely used by health care providers and planners to set priorities and allocate resources to effectively address needs and service gaps, and to develop strategic plans (for a more comprehensive profile of the health system, see Appendix F).

Population Characteristics

Population Profile

Erie St. Clair, the southernmost LHIN, comprises Essex County, the Municipality of Chatham-Kent, and Lambton County. It is home to over 640,000 people, or 4.8 per cent of the population of Ontario. During the years 2006–11, the population of Erie St. Clair decreased by 1.6 per cent, while Ontario's population grew by 5.6 per cent.

Erie St. Clair has a growing seniors' population, and is aging faster than the province as a whole, while our younger population, those between 0 and 44 years, is decreasing. In 2011, almost 16 per cent of the population were seniors (aged 65+), an increase from 14 per cent in 2006. Compared to the rest of Ontario, Erie St. Clair has a slightly higher proportion of the population over the age of 60 and a slightly lower proportion of the population between the ages of 30 and 34. These differences in age distribution are most pronounced in the Chatham-Kent and Sarnia/Lambton communities.

Of the total Erie St. Clair population, 17.0 per cent live in Chatham-Kent, 62.5 per cent in Essex County and the remaining 20.5 per cent in Lambton County. Compared to the province as a whole, Erie St. Clair has a larger rural population (5.4 per cent larger). Population density is also considerably higher in Erie St. Clair (approximately 70 more people per square kilometre) than in the province.

At the county level, the population has declined by 4.2 per cent in Chatham-Kent, 1.6 per cent in Lambton, and 1.2 per cent in Essex. Between 2011 and 2016, the population is expected to experience slow growth and increase by only 3,686 residents (0.6 per cent); by 2021, it is forecast to increase by 1.6 per cent. During the same period, it is projected that the population of Ontario will grow by 13 per cent.

Of the total Erie St. Clair population, 3.3 per cent identify as Francophone (i.e., claim French as their mother tongue), which is slightly lower than for the province as a whole. The Francophone population is also much older than the general population: seniors represent 24 per cent of this group, in comparison with 16 per cent in the general population. Education and revenue levels are also lower than for the general population. Out-migration of Francophone youths is of particular concern to the community.[8].

The proportion of the population identifying itself as Aboriginal in Erie St. Clair has increased slightly since 2006, and is now 0.4 per cent higher than for the province as a whole. The largest numbers of Aboriginal people — 43 per cent — live within Windsor/Essex; 39 per cent live in Sarnia/Lambton, and 18 per cent in Chatham-Kent, with the majority living off-reserve in Ontario. Within Erie St. Clair, while Aboriginal people have access to Community Health Centres, they do not have local access to Aboriginal Community Health Centres (ACHC) or Aboriginal Health Access Centres (AHAC), which are considered to be the best primary care model for them.

Although there has been a slight increase across the province in the proportion of the population that are immigrants or visible minorities, Erie St. Clair continues to be notably less diverse than the province as a whole. Within ESC LHIN, Essex County consistently has a greater proportion of immigrants, at 22.4 per cent, and visible minorities, at 14.2 per cent.

In 2011, ESC LHIN had the third-highest rate of unemployment in the province and, in 2006, the proportion of those living in a low-income household was 12.2 per cent lower than the provincial rate of 14.7 per cent.

The proportion of families with children headed by one parent has decreased to 15.7 per cent and is now 0.1 per cent lower than for the province as a whole. The prevalence of a decrease in one-parent families is similar across all of the Erie St. Clair counties.

Table 7 provides detailed population statistics for Erie St. Clair.

[8] Statistics Canada, 2012, *Highlight Tables — Language, 2011 Census*, Statistics Canada Catalogue no. 98-314-XWE2011002, released on October 24, 2012.

Table 7: Erie St. Clair Population Demographics (2011 Census of Canada)

	Chatham-Kent	Windsor/ Essex	Lambton	Erie St. Clair			Ontario
Population Demographics	**2011**	**2011**	**2011**	**2011**	**Change 2006–11**	**Difference from Ontario**	**2011**
Population							
Total population	108,580	403,396	131,415	643,391	↓	5.6%	13,372,996
65–74 years	1.6%	5.1%	2.0%	8.69%	↑	7.1%	↑
75 years+	1.4%	4.5%	1.8%	7.69%	↑	6.4%	↑
Language							
Percentage of population with English as mother tongue	87.5%	73.8%	89.9%	79.4%	↓	9.6%	69.8%
Percentage of population with French as mother tongue	3.0%	3.6%	2.5%	3.3%	↓	-1.1%	4.4%
Immigration and Ethnic Origin							
Percentage of population that are immigrants	10.1%	22.4%	11.6%	18.1%	↑	-10.2%	28.3%
Percentage of population that arrived within last five years	1.0%	3.9%	0.8%	2.8%	↓	-2.0%	4.8%
Percentage of population that are visible minorities	4.3%	14.2%	2.7%	10.1%	↑	-12.7%	22.8%
Percentage of population identifying as Aboriginal	2.5%	1.6%	4.6%	2.4%	↑	0.4%	2.0%

Table 7: Erie St. Clair Population Demographics (2011 Census of Canada) (cont'd)

	Chatham -Kent	Essex	Lambton	Erie St. Clair			Ontario
Population Demographics	**2011**	**2011**	**2011**	**2011**	**Change 2006–11**	**Difference from Ontario**	**2011**
Labour Force							
Percentage of population aged 15+ in the labour force	65.8%	64.8%	64.3%	64.8%	↓	-2.3%	67.1%
Education							
Percentage of population without certificate, degree, or diploma	20.9%	15.4%	13.0%	15.8%	↓	-2.3%	13.5%
Percentage of population aged 25+ that have completed post-secondary education	49.0%	55.4%	58.2%	54.9%	↑	6.5%	61.4%
Family							
Percentage of families with children that are headed by one parent	15.1%	16.4%	14.3%	15.7%	↓	0.9%	15.8%
Housing							
Percentage of non-owned private dwellings	2.5%	1.7%	4.7%	2.4%	↑	-0.5%	2.0%
Low Income							
Percentage of population with low income	11.9%	13.1%	9.4%	12.2%	↓	-2.5%	14.7%

Source: Statistics Canada, 2006 Census, www.statcan.gc.ca.

Economic Challenges

The current economic challenges, which began in 2008, have resulted in a disproportionately high unemployment rate in Erie St. Clair compared to the rest of the province. This high rate may be exacerbated by the fact that the population of Erie St. Clair has lower levels of education than the province as a whole. Approximately half of the population (54.9 per cent) has completed post-secondary education, while 15.5 per cent of the population does not have a certificate, degree, or diploma. Levels of education are highest in Sarnia/Lambton and lowest in Chatham-Kent.

From 2006 to 2011, the unemployment rate in Erie St. Clair decreased slightly, to 7.5 per cent, which is higher than the 6.4 per cent unemployment rate for the rest of Ontario. Unemployment was highest in Essex (7.9 per cent) and lowest in Sarnia/Lambton (6.5 per cent). After the dramatic changes that occurred in the Canadian economy between 2009 and 2011, however, the employment situation in Erie St. Clair shifted. In 2011, the unemployment rate in Windsor/Essex decreased slightly, to 9.3 per cent, which was higher than the provincial average of 7.8 per cent. The localized unemployment rate in the Municipality of Chatham-Kent (8.8 per cent) is higher than the provincial average.[9]

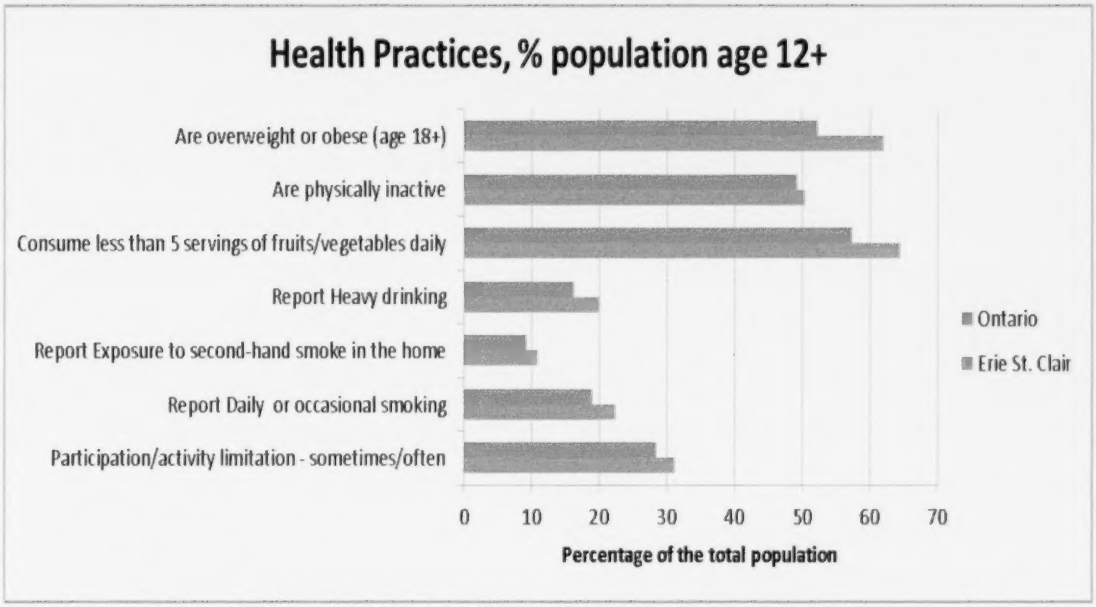
Overall, the economic challenges of the past few years have had a disproportionate impact on the Erie St. Clair region. It is anticipated that the economic and employment situation will result in an increased need and demand for social services and mental health and addiction services within Erie St. Clair. In summary, ESC LHIN has significant concerns about the pending impact of the economic situation on the demand for services and performance implications within the local health care system.

Health Status and Chronic Conditions

The residents of Erie St. Clair perceive that they are healthier than they actually are. Residents in this region have a lower life expectancy rate, a higher age-standardized mortality rate, and a higher potential years-of-life-lost rate compared to rates for the province. Poor health practices correlate with an increased risk of chronic disease, mortality, and disability. Relative to the rest of the province, residents of Erie St. Clair report higher rates of smoking, alcohol consumption, and obesity, and lower rates of physical activity and healthy eating (see Figure 6). These factors place the residents of Erie St. Clair at a higher risk for developing chronic conditions, especially diabetes.

[9] Health Analytics Branch, MOHLTC, *MOHLTC Environmental Scan.*

Figure 6: Health Practices, Percentage of Population Aged 12+



Source: Statistics Canada, *2007 Canadian Community Health Survey (CCHS), Ontario Share File.*

Health status information indicates that life expectancy among males and females in Erie St. Clair is lower than life expectancy for Ontarians overall (see Table 8). Since 2006, female life expectancy at birth increased by 0.6 years for Erie St. Clair and 0.9 years for Ontario. During the same period, male life expectancy at birth in Erie St. Clair increased by 1.0 years. Between 2006 and 2011, male life expectancy in Erie St. Clair increased at a higher rate than female life expectancy.

Table 8: Life Expectancy in Erie St. Clair

	Erie St. Clair			Ontario	
	2011	Change since 2006	Difference from Ontario	2011	Change since 2006
Life expectancy at birth, males (years)	78.2	↑	1.0	79.2	0.6
Life expectancy at birth, females (years)	82.4	↑	-1.2	83.6	0.9

Chronic conditions place a high burden on the health care system and reduce the quality of life for those who have one or more of these conditions. Forty-one per cent of Erie St. Clair residents (aged 12+) have a chronic condition and 17 per cent have multiple conditions. The prevalence of multiple chronic conditions increases dramatically with age: more than half of Erie St. Clair residents aged 65+ have two or more chronic conditions. Chronic conditions account for 6 of 10 deaths, 1 of 4 acute hospital admissions, and 3 of 10 acute hospital days for Erie St. Clair residents.

Table 9 illustrates that, compared to Ontario, Erie St. Clair had higher rates of the following chronic conditions (in order from highest to lowest) in 2009: arthritis, hypertension, diabetes, asthma, heart disease, and COPD. For all age groups, arthritis and hypertension are the most common of the selected chronic conditions. As well, Erie St. Clair residents over the age of 65 have the highest occurrence rates for all of the selected conditions (except asthma) compared to Ontario.

Table 9: Prevalence Rates for Selected Chronic Conditions, Erie St. Clair and Ontario, 2007 and 2009

	Erie St. Clair				Ontario		
	2009	**2007**	**Change Since 2007**	**Difference from Ontario**	**2009**	**2007**	**Change Since 2007**
Arthritis	21.9	20.9	↑	4.7	17.2	16.4	↑
Hypertension	19.9	17.3	↑	2.5	17.4	16.4	↑
Diabetes	7.7	7.3	↑	0.8	6.9	6.1	↑
Asthma	7.6	10.4	↓	-0.8	8.4	8.2	↑
Heart disease	5.2	4.6	↑	0.3	4.9	5.0	↓
COPD	3.8	6.2	↓	-0.4	4.2	N/A	N/A
Cancer	1.8	1.9	↓	-0.1	1.9	1.5	↑
Stroke	1.5	1.4	↑	0.4	1.1	1.3	↓

Source: Statistics Canada, *2009 Canadian Community Health Survey (CCHS), Ontario Share File.*

Assessment of Service Utilization

The point of access for most medical care is through a primary care physician. The majority of Erie St. Clair residents have a regular primary care physician (90.9 per cent), with 82.8 per cent having had at least one contact with a physician in the past year. The Ministry of Health and Long-Term Care's Health Care Connect (HCC) program — which helps Ontarians who don't have a family doctor, find one — began in February 2009. Between February 2009 and April 2012, 10,660 Erie St. Clair residents registered with the program, and 94 per cent of them have been referred to a primary care provider through HCC.

In ESC LHIN, there are a total of 87 health service providers, including:

- Community Care Access Centre
- Community Health Centres
- Community Support Services
- Hospitals
- Long-Term Care Homes
- Mental Health and Addictions

A significant number of ministry-funded services do not fall under the LHIN mandate, including most physician services, ambulance services, public health, drug benefits, laboratories, and independent health facilities.

Across the Erie St. Clair region, opportunities exist to improve both access to and appropriate utilization of EDs. Emergency department services are available across all hospitals in Erie St. Clair. As with many hospital EDs, Erie St. Clair's EDs are facing a variety of operational issues. For example, the facilities need more NPs and physicians in order to maintain current levels of service.

In 2010–11, patients assessed at the Canadian Triage and Acuity Scale (CTAS) 4 and 5 (less urgent and non-urgent) continue to present at the ED for various reasons. These visits account for 44 per cent of all ED visits across the Erie St. Clair region. Erie St. Clair EDs are also experiencing physical space pressures as they work to safely care for patients (due to increasing ED LOS). Although the Erie St. Clair ED LOS was just below the provincial average (8.0 hours compared to 8.2 hours), there are specific opportunities within the region to continue addressing the increase in ALC cases and how these cases directly affect ED LOS.[10]

From a patient flow perspective, providing Better Care, Better Experience, Better Value continues to be a system challenge across the Erie St. Clair region. During 2011–12, ALC rates continued to affect patient flow and patient experience. The ALC rate for 2011-12 increased in the final quarter to 12.82 per cent (above the ESC LHIN target rate of 12 per cent), for example. Several initiatives have been launched to help reduce this number, such as prioritizing implementation of the Home First program and exploring opportunities to repurpose idle LTC beds with restorative-type programming for frail individuals.

[10] MOHLTC, Health Analytics Branch – *Quarterly Stocktake Report*.

In 2010–11, hospital statistics demonstrated that patients in the Erie St. Clair region who had a diagnosis of COPD accounted for the largest proportion of acute care days and ALC patient days. Erie St. Clair had the largest proportion of ALC patients discharged to complex continuing care facilities; as well, the top three diagnoses for ALC cases in Erie St. Clair were dementia, ischemic events, and heart failure.

Achievements

Erie St. Clair LHIN's IHSP 3 will continue to build on the progress realized in a number of key areas over 2011–12, including:

- Emergency department wait times:

  Erie St. Clair LHIN continues to monitor ED wait times for all five hospitals for high-acuity admitted patients, high-acuity non-admitted patients, low-acuity patients, physician initial assessment, and time to in-patient bed. This is a key LHIN priority. The pay-for-results (P4R) program is monitored (in collaboration with the ESC LHIN lead and the ED/ALC manager) on a monthly basis, and the goal is to reduce ED wait times and monitor performance and financial accountability through quality process improvement planning, evidence-based practice, and redesign strategies. Frequent site visits are arranged with each P4R hospital in order to monitor progress, address challenges, and align with ESC LHIN strategies and programs required for improved performance. Network forums for all participating P4R hospital Leads and community support services are provided in order to enhance opportunities to share best practices, innovative solutions, and lessons learned. The P4R Network Forums aim to develop a coordinated, consistent, and integrated approach across ESC LHIN.

  In 2012, MOHLTC implemented primary care physician LHIN Lead positions in order to advance primary care services to support timely, accessible, and effective primary care and to prevent unnecessary ED visits. The Erie St. Clair Primary Care Physician LHIN Lead created a Primary Care Council to advise ESC LHIN on improving integration and quality improvement within Erie St. Clair's primary health care system. The Council's first initiative is focused on reducing avoidable ED visits and avoidable hospitalizations for COPD patients in Chatham-Kent.

- Alternate level of care:

  Erie St. Clair continues to experience an increasing percentage of patients designated ALC, which impairs smooth transitions and improved patient flow. In July 2011, ESC LHIN instituted a coordinated LHIN-wide approach and structure to address the ALC issue across the entire region, to ensure a coordinated systematic approach and process improvement from all health care providers and sectors (e.g., hospitals, CCACs, primary care teams, community support services, the LTC sector, etc.). In September 2011, the Home First program, in partnership with ESC CCAC, was implemented with a LHIN-wide focus on priority populations. The Home First Steering Committee provides oversight to the Home

First implementation philosophy, and supports an innovative, systematic, integrated approach to resolving ALC issues within each local geographical area. Further work to improve patient flow is being done through the LHIN Rehabilitation Network, which recently completed a *Rehabilitation System Strategic Plan for the Erie St. Clair Region* that will be implemented in January 2013 (see Appendix G).

- Chronic disease management:

  In June 2012, the ESC LHIN board approved its strategic plan. A key goal identified through this process is the need to realign the health care system so that people with chronic diseases receive better regular care, are better able to self-manage their conditions, and are less reliant on emergency and acute care services. Key chronic populations identified included those living with COPD, CHF, and complex conditions. Work has begun in the Chatham-Kent region to advance a COPD Integrated Care Path/Model. The main objectives of this work are to: 1) establish accountability to patients by improving access to care and better incorporating the patient experience into planning and care; 2) improve the health of the COPD population; 3) better manage the costs of COPD care, ensuring a sustainable system is available in the longer term; 4) promote innovation through best practice uptake; and 5) continue to build capacity through quality improvement. The COPD Care Path development process has been directly linked to the work of the Primary Care Council, ensuring better access to ongoing primary care and the maintenance of chronic illnesses.

  Work is also continuing on the implementation of a Central Intake Referral Form to facilitate a smoother process for health care providers and patients who need to access diabetes care services. Erie St. Clair LHIN continues to promote the development and dissemination of key clinical pathways for diabetes care, foot care, and optometry to relevant stakeholders and primary care providers. Quality improvements through the uptake of best practices continue to be a priority focus for this population.

  Finally, work on improving patient care for people with CHF will begin in 2013 using the results from the report that was released in August 2012 by the Cardiac Care Network of Ontario, the Heart and Stroke Foundation, and the Ontario Stroke Network, entitled *Shaping the Future of Vascular Health: An Integrated Vascular Health Blueprint for Ontario*.

- Mental health and addictions:

  Between 2009 and 2012, ESC LHIN approved the transition of 59 specialized mental health beds (tier II) to Windsor Regional Hospital. The tier II funding was finalized in November 2011, and it immediately increased local bed capacity.

  A strategic planning process was implemented in fiscal 2012. System redesign and increasing community capacity are the focus of the *Erie St. Clair Mental Health Strategic Plan for Erie St. Clair 2012–2016 (*see Appendix H), which focuses on adult mental health. Embedded in the plan are future vision statements, plans for increased community mental health service delivery, and performance-based advancement plans to decrease mental

health ED repeat visits and re-admissions within 30 days. The plan's development was overseen by an advisory committee comprising consumer–family initiatives, community mental health providers, and tertiary mental health providers. The plan is anticipated to strengthen the role for integrated, community-based mental health services as well as foster better partnerships with primary care providers.

In 2012, ESC LHIN, in partnership with the Ontario Tele-Medicine Network, provided video-conferencing equipment for seven HSPs to enhance services for addiction clients. As part of the Opiate Dependency Strategy, ESC LHIN provided enhanced funds for a Caring Connections Program, which focuses on assisting pregnant and/or parenting women who have an addiction. The program is run in partnership with local child welfare organizations and Ontario Early Years Centres, and focuses on children aged 0–6. The Opiate Dependency Strategy also includes:

- Start-up funds for the new Sarnia/Lambton Withdrawal Management Services
- New therapist position for the Bluewater Methadone Clinic
- New therapist position for the Erie St. Clair Methadone Clinic in Windsor

Section 6: Priorities and Strategic Directions for the Local Health Care System

Overview

This section is divided into two parts:

Part 1 looks at the adoption of a more focused approach to achieving our priorities through targeting hot spots within the strategic directions.

Part 2 examines the short-term (six-month to one-year) tactics that will be implemented over the plan's three years.

These tactics are intended to produce measurable results that better address the clinical and functional needs, as well as utilization behaviours, of high users of the local health care system. The tactics are also intended to help address the impacts of funding reform.

As we continue to build on previous successes and the efforts already underway, the four key strategic priorities for IHSP 3 are:

1. Improved outcomes in alternate level of care
2. Improved outcomes in the emergency department
3. Improved outcomes in chronic disease management
4. Improved outcomes in mental health and addictions

Additional rationale is provided for each of these priorities, to:

1. Identify why the priority continues to be important
2. Identify the three-year goals and tactics
3. Identify priority populations
4. Identify success measures

For more information, see Appendix I.

Hot Spots

Hot spots help ESC LHIN:

- Better align planning with local needs and issues
- Address high users of the health care system
- Consider the longer-term sustainability of the system

Hot spots refer to specific local populations and/or defined geographic areas where evidence of higher utilization, or inappropriate utilization, of health care resources can be seen (e.g., because other options for care may not exist). Hot spots also occur because of restricted utilization as a result of barriers to care (which manifests itself through higher rates of ED utilization). Hot spots comprise specific populations that have a significantly higher prevalence of disease than the general population, and can be seen in an identifiable area.

Information on hot spots is used to pinpoint, identify, and confirm priority populations and/or specific geographic areas of need that will benefit from immediate, intense intervention that produces the greatest return on investment for our region. Predictably, this assessment targets high users of the health care system (the 1 per cent of the population that consumes the most significant health care resources and the 5 per cent of the population that is at risk of becoming part of the 1 per cent). Generally, these users arrive frequently at EDs and doctor's offices with an array of complicated medical and social issues, resulting in undue strain on community resources.

Tactical Approaches

In the final part of this section, a number of specific tactics and projects are introduced to directly address the hot spots and to help high users of the health care system improve their access to health care and better manage their chronic conditions. Tactics are measures and actions that will be put in place to address an identified strategic direction or goal. These actions are expected to have a direct impact on the key measures that ESC LHIN is attempting to implement. The anticipated result is healthier residents, reduced ED visits, improved patient flow from hospital to community services, and lower overall health care costs.

Part 1: Local Hot Spot Assessment

This part contains specific information on high users of the health care system, and addresses ED repeat users, hospital readmissions, and ALC long-stay patients. The intent of this assessment is to target specific populations and/or geographical areas within the region, and to advance tactics and projects aimed at directly addressing users' health service needs over a 12- to 36-month period. This approach will result in the directing of scarce resources to areas of greatest need (aligned with provincial and local regional priorities) in order to obtain the highest return on investment for our region.

High Users of the Health Care System

A recent assessment of high users of the health care system (April 2012) by the Health Analytics Branch, MOHLTC, found that the number of these users varies considerably across Ontario's LHINs, from 14.5 to 49.9 per 1,000 population. ESC LHIN has 31.8 high users per 1,000 population. It is important to note that Windsor/Essex has the second-highest volume of cases in the province, at 12,855 high users of the health care system. Further analysis reveals that Sarnia/Lambton and Chatham-Kent have higher rates of these users in comparison to the province.

High Users of Emergency Departments

In performing an assessment of emergency services utilization in ESC LHIN, the Health Analytics Branch, MOHLTC, found that the top 10 per cent of high users of the ED are patients requiring cardiac, respiratory, and digestive interventions. The highest volume of ED users for the region presented with the following conditions:

1. digestive disorders (11,250 episodes, at a cost to the system of $4.5 million)
2. circulatory disorders (8,540 episodes, at a cost to the system of $4 million)
3. respiratory disorders (6,675 episodes, at a cost to the system of $3 million)

Emergency Department Repeat Visits

A further assessment[11] of ED repeat visits of high users of the health care system (by major ambulatory cluster) found that, on average, Windsor/Essex has the highest utilization rates by volume across the Erie St. Clair region (see Table 10).

Table 10: Two-Year ED Repeat Visit Utilization Rate by Volume (by Major Ambulatory Clusters [MACs])

Area	Diagnosis Populations (MACs)	ED Utilization Rates (Readmissions within One Year) by Patient Type
Windsor/Essex	Digestive	4,481
	Circulatory	2,927
	Respiratory	1,862
Chatham-Kent	Digestive	1,702
	Circulatory	935
	Respiratory	1,016
Sarnia/Lambton	Digestive	2,072
	Circulatory	1,094
	Respiratory	1,444

*Average over 2009–10 and 2010–11. Source: Health Analytics Branch, MOHLTC, *Intellihealth 2009–2011.*

Hospital Readmissions

Within Erie St. Clair, populations for hospital readmissions were consistent across the region. The main categories for readmission were cardiac (myocardial Infarction, heart failure and ischemic heart disease, fractures, digestive disorders, and respiratory disorders.

[11] Health Analytics Branch, MOHLTC, *Intellihealth 2009–2011.*

ALC Bed High-Stay Patients

Between June and October 2011, ALC hospital long-stay patient trends in the Erie St. Clair region were assessed in order to acquire a better understanding of high users' utilization patterns. The analysis indicated that, over this period, a 15 per cent increase in ALC days occurred, with only a 3 per cent increase in ALC cases.

Further analysis identified that the change in ALC days represented a 16 per cent increase in post-acute service components (including ALC rates in CCC, rehabilitation, and mental health). The acute service component showed a similar 14 per cent growth in ALC days over the same period. The average ALC LOS for ALC cases increased in the acute care component by 13 per cent, to 14.1 days, while the average ALC LOS for ALC cases increased in the post-acute service component by only 3 per cent. The opening of sub-acute restorative beds, which had the effect of generating lower ALC LOS for ALC cases for post-acute patients, is one reason for this trend.

Across the Erie St. Clair region during this period, the highest ALC LOS for ALC cases in post-acute occurred at Bluewater Health (BWH) and Windsor Regional Hospital (WRH), at approximately 66 and 58 ALC days, respectively, per ALC case. On the acute side, Bluewater Health and Hôtel-Dieu Grace Hospital (HDGH) had the highest ALC LOS per ALC case, at 23 and 20 ALC days, respectively.

Further assessment of actual volumes revealed that, on the acute side, the highest number of ALC days occurred at Hôtel-Dieu Grace Hospital, with 14,900 days or 40 per cent of the total. On the post-acute side, WRH experienced a total of 18,700 days, or 56 per cent of total utilization for the period. Finally, an assessment of ALC LOS across the Erie St. Clair region for combined acute and post-acute patients showed that the highest overall LOS was in Sarnia/Lambton, at 37 days, followed by Windsor/Essex at 22 days and Chatham-Kent at an average of 7 days.[12]

Other Hot Spot Populations

Within Erie St. Clair, additional hot spot analysis showed that:

- Arthritis continues to be an issue for Erie St. Clair residents. This condition is 36 per cent higher in Sarnia/Lambton and 28 per cent higher in Windsor/Essex than it is for the province as a whole
- Smoking continues to be a challenge in the Erie St. Clair region

[12] Health Analytics Branch, MOHLTC, *MOHLTC Environmental Scan*.

Ambulatory-sensitive conditions (populations receiving care in a hospital setting, rather than in a clinic or primary care setting) per 100,000 population are highest in Chatham-Kent and Sarnia/Lambton.[13]

Part 2: Local Consolidated Tactical Approach (12 to 36 Months)

Based on the results of the hot spot analysis, ESC LHIN will advance the following priority tactics and projects in order to address needs and to achieve identified strategic directions. These projects will become the focus of ESC LHIN-managed strategic care for the next six months to one year. Erie St. Clair LHIN strategic directions are not mutually exclusive, and thus the identified populations receive care in a number of settings, and so tactics introduced in one area may also have a positive impact on other strategic directions.

[13] Ibid.

Strategic Direction: Improved Outcomes in Alternate Level of Care
Population/Hot Spot Focus
- ALC patients with diagnosis whose acute stay would be shortened if they received intensive rehabilitation services - High-risk frail seniors aged 65+ - Potential assisted-living patients currently in CCC, assess and restore, and/or convalescent beds - Individuals and/or families living with a progressive, life-limiting illness - Frequently readmitted CDM patients
Priority Tactics/Projects (Next 12 to 36 Months)
- Initiate *Rehabilitation System Strategic Plan for the Erie St. Clair Region*: o Identify and implement best practices for top three rehabilitation clinical conditions o Facilitate appropriate use of inpatient rehabilitation beds o Ensure adequate access to outpatient and community rehabilitation services - Increase assisted-living capacity/beds ESC LHIN-wide - Continue to implement ESC LHIN-wide falls prevention initiative - Support the development of residential hospice services in Chatham-Kent and Leamington - Enhance the primary care role in managing end-of-life patients - Support Leamington District Memorial Hospital Seniors Centre of Excellence Strategy - Transform 2 per cent of all LTC beds into convalescent care beds - Initiate early warning risk assessment tool (the LACE index — length of stay, acuity, comorbidity, and emergency department visits within six months)

Strategic Direction: Improved Outcomes in Alternate Level of Care (cont'd)
Rationale for Choice
- Consistent with overall directions outlined in *Rehabilitation System Strategic Plan for the Erie St. Clair Region* - Deconditioning is a problem for ALC patients; results in increased LOS - Maximize functional capacity and satisfaction - Promote patient flow out of acute care to more community options - Assisted-living and convalescent care options expected to promote patient flow - End-of-life patients accounted for 10.3 per cent of ALC discharges and 9.3 per cent of ALC days - Positively supports Health Based Allocation Model (HBAM) and health system funding reform - Supports Ontario's Seniors Strategy
Success Measures (12–36-Month Anticipated Impact)
- Reduce acute ALC to 9 per cent ESC LHIN-wide - Reduce the need for hospital acute services (inpatient discharges) within the next three years to meet the provincial discharge rate of 100 per cent - Meet the target of 7,250 new patient days (equal to 20 beds) for assisted living in Windsor/Essex - Meet the target of 7,250 new patient days (equal to 20 beds) for assisted living in Chatham-Kent and Sarnia/Lambton - Reduce hospitalizations due to falls from 12 to 11.2 (rate per 1,000) for those aged 65+ within three years - Maintain ALC throughout ratio at or above provincial target (i.e., greater than one)

Strategic Direction: Improved Outcomes in Emergency Department
Population/Hot Spot Focus
- High users of the ED - High-risk seniors aged 65+ - Individuals with multiple chronic diseases - Mental health and addiction users of ED services - Aboriginal people not attached to a primary care provider - Individuals and/or families living with a progressive, life-limiting illness
Priority Tactics/Projects (12 to 36 Months)
- Improve core discharge planning/policies and transition processes from hospital to community through standardization - Initiate an early-warning, high-risk identification process for potential repeat ED users - Continue to develop recruitment and retention initiatives for the ED - Evaluate the Home First initiative and readjust per revised plan - Improve leadership and interfaces between care settings: o Hospital o Nurse Practitioner Lead Outreach Team o Primary care o Community support services (CSS) - Utilize decision support team to identify high users of the ED who have diabetes - Increase the number of Aboriginal people with a primary care provider - Continue to initiate education collaborative in hospice palliative care, with an emphasis on best practice uptake in all care settings - Initiate a virtual team to improve access to end-of-life care specialists

Strategic Direction: Improved Outcomes in Emergency Department (cont'd)
Rationale for Choice
- Supports MLPA targets - Identifies and addresses the needs of high users of the ED by redirecting them to more appropriate care alternatives - Aboriginal people in Ontario have a poorer overall health status and are not receiving a proportionate level of primary care support or culturally safe care - Across Ontario, more than 80 per cent of hospice palliative care patients were admitted via EDs, compared to 50 per cent of other patients - Positively supports HBAM and health system funding reform - Supports Ontario's Seniors Strategy
Success Measures (12–36-Month Anticipated Impact)
- Reduce ED visits ESC LHIN-wide from 1,247 to 944 within three years for individuals with COPD aged 35+ (rate per 100,000 population) - Reduce ED visits ESC LHIN-wide from 456 to 362 within three years for individuals with CHF aged 35+ (rate per 100,000 population) - Reduce 30-day repeat visits to the ED by 5 per cent within three years for people with mental illness and addictions - Divert 10 per cent of current inappropriate hospital mental health visits to the community sector - Reduce avoidable ED visits for people with diabetes by 2 per cent within three years - Reduce avoidable palliative care visits to the ED to reach 10th percentile of provincial performance - Increase the percentage of Aboriginal people attached to a family physician/primary care provider in a culturally safe primary care setting by 20 per cent

Strategic Direction: Improved Outcomes in Chronic Disease Management
Population/Hot Spot Focus
- Individuals with COPD - Individuals with CHF - Individuals who have suffered a stroke - Individuals with complications/high needs due to diabetes - Individuals with complications due to digestive disorders - Aboriginal people with a chronic disease and co-morbidities - Individuals and/or families living with a progressive, life-limiting illness - Francophone seniors with a chronic disease and co-morbidities
Priority Tactics/Projects (12 to 36 Months)
- Advance LHIN-wide standardized COPD Care Path - Initiate CHF Care Path development (beginning in Windsor/Essex) - Advance an ED and hospital discharge protocol for COPD - Implement a centralized intake process LHIN-wide for diabetes based on Windsor/Essex model (beginning in Chatham-Kent) - Advance a LHIN-wide Care Path for diabetes - Advance/link with more culturally based models of care - Enhance hospice palliative care programming in all hospitals - Establish Francophone primary health care hub - Develop a primary care plan for the Aboriginal population across ESC LHIN, including the urban Aboriginal population and Métis people - Continue development of the Community Health Centre (CHC) satellite site on Walpole Island

Strategic Direction: Improved Outcomes in Chronic Disease Management (cont'd)
Rationale for Choice
- Consistent with COPD Care Path development and implementation process currently underway in Chatham-Kent - Aligned with *Primary Care Council Strategic Work Plan Goals* - Evidence-based discharge protocols exist but are not being used consistently across all hospital sites - Need to promote strong links between primary care, EDs, and CSS to better support patients with chronic diseases - Need to simplify the access and navigation processes related to chronic disease management - Need to ensure more timely access to care for persons with a chronic disease - Positively supports HBAM and health system funding - Supports Ontario's Seniors Strategy
Success Measures (12–36-Month Anticipated Impact)
- Reduce 30-day re-admissions from 24.5 per cent to 12 per cent within three years for individuals with COPD aged 35+ - Reduce 30-day re-admissions from 18.8 per cent to 12 per cent within three years for individuals with CHF aged 35+ - Reduce admissions from 322 to 280 within three years for individuals with CHF aged 35+ (rate per 100,000 population) - Reduce admissions from 417 to 330 within three years for individuals with COPD aged 35+ (rate per 100,000 population) - Reduce high blood pressure within the Erie St. Clair population from 19.7 per cent to 17.7 per cent within three years - Reduce the daily or occasional smoking rate within three years from 22.2 per cent to 18.9 per cent - Achieve a 2 per cent reduction in ED diabetes visits - Achieve a 2 per cent reduction in LOS for hospitalized diabetes-related complications - Place 90 per cent of complicated COPD, CHF, and diabetes patients on a multidisciplinary Care Path

Strategic Direction: Improved Outcomes in Mental Health and Addictions
Population/Hot Spot Focus
- High users of the ED (1 per cent of the population) - Repeat users of the ED for mental health and addictions - Aboriginal people with mental health and addictions - Opiate-dependent patients - Individuals in need of withdrawal-management services - Older adults with responsive behaviours - Francophone patients with mental health issues
Priority Tactics/Projects (12 to 36 Months)
- Initiate *Mental Health Strategic Plan*: o Connect frequent users of the ED with community supports in Chatham-Kent and Sarnia/Lambton o Establish an Inner City Mental Health Model in Windsor/Essex to redirect frequent users of the ED to community supports o Develop a virtual network of providers to serve the Francophone population - Establish ED tracking protocols for opiate-dependent patients needing withdrawal-management services LHIN-wide - Open withdrawal-management services in Sarnia/Lambton in 2013 - Continue to implement Behaviour Support Ontario (BSO) initiative - Review and implement the joint LHIN Aboriginal Mental Health and Addiction Strategy

Strategic Direction: Improved Outcomes in Mental Health and Addictions (cont'd)
Rationale for Choice
- Consistent with overall directions outlined in the *ESC LHIN Mental Health Strategic Plan* - Supports MLPA target to reduce repeat ED visits for mental health and addictions within 30 days - ESC LHIN addiction repeat visits to the ED are the third-highest in the province - The Inner City Mental Health Initiative has had a high degree of success in other areas of reducing/redirecting mental health repeat ED visits to more appropriate community care alternatives - Positively supports HBAM and health system funding reform
Success Measures (12–36-Month anticipated impact)
- Decrease the number of high users of the ED who have a mental illness and who are not attached to community-based mental health services at a rate of five to eight clients per quarter - Decrease the number of repeat ED visits by 10 per cent within three years - Reduce ALC days by 5 per cent for people with specialized behavioural needs - Place 50 per cent of persistent, complicated mental health clients on a community plan on discharge - Reduce inpatient gero-psych admissions by 10 per cent - Reduce the wait time for withdrawal management and addiction medicine services by five days - Increase successful residential treatment and compliance rates increase by 20 per cent

Section 7: Conclusion and Next Steps

The *Integrated Health Services Plan 3* is a directional document that guides ESC LHIN's work for the next three years. The plan provides a blueprint for ensuring full support and local alignment with MOHLTC key priorities for Ontario. As identified through our community engagement processes, IHSP 3 addresses the immediate needs of our local population and establishes priorities that are intended to improve overall system access, quality, and cost-effectiveness. The plan also supports the wider aim of promoting coordination and integration, and is intended to serve as a catalyst for positive change.

Integrated care means bringing together inputs, delivery, management, and the organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. At the organizational level, integration is viewed a process of coordination that seeks to achieve seamless and continuous care, tailored to the patient's needs and based on a holistic view of the patient.

Important goals of integrated care include both improving access and better coordination of care. This increases the efficiency and quality of our local health care system, and results in better patient outcomes and satisfaction. This plan recognizes that successful execution is only possible with a concerted effort involving the collective support of all our health service providers, stakeholders, and the community. Through this plan, ESC LHIN hopes to advance opportunities that:

- **Enhance access to health care**, ensuring that quality care is available where people need it
- **Help people live longer and healthier lives**, through better management of care, health promotion, and illness prevention
- **Enhance evidence-based practices** to improve safety
- **Promote integration** from a patient care perspective
- **Achieve all of the above** at the lowest possible cost

The plan's success depends on continued strong, visionary leadership; a commitment by all interested parties to work toward a common vision and goals; strengthened accountability processes; and, most importantly, demonstrated results.

Next Steps

ESC LHIN believes that it is crucial to continue to establish high-level health care system strategic performance targets that link directly to our strategic plan, and to MLPA. These targets will also provide guidance to the annual business plan. Progress toward achieving these targets (within the three-year timeframe) will be measured quarterly, and results reported in a standard score card format.

The performance improvement targets outlined in Table 11 were reviewed by a community engagement process involving many stakeholders, including health service providers (both front-line and administrative), Aboriginal groups, French-language groups, ESC LHIN advisory networks, and ESC LHIN board members (including the Leadership Councils).

Table 11: Three-Year Strategic Targets for the Erie St Clair Health Care System

		Where we are	Where we want to go		
	ESC LHIN Total Volumes	ESC LHIN Rate per 1,000 Pop'n OR % Total	Proposed ESC LHIN Rate per 1,000 Pop'n OR % Total	Impact on ESC LHIN	Change required to meet target
Acute Care					
Acute separations	51,695	80.3	71.6	**5,612** fewer acute separations	-11%
Total Days	329,745	512.5	470.7	**26,846** fewer total days	-8%
Acute Days	287,416	446.7	391.7	**35,398** fewer acute days	-12%
ALC					
%ALC Discharges to Long-term Care	**2,543**	14.9%	9.2% (HNHB LHIN)	**145** fewer discharges to LTC	-38%
%ALC Discharges to home with support	**2,543**	17.5%	25.4% (HNHB LHIN)	**201** more discharges home with support	+45%
%ALC Discharges to Chronic Care	**2,543**	28.1%	19.5% (MH LHIN)	**219** fewer discharges to Chronic Care	-31%
%ALC Discharges to Rehabilitation	**2,543**	17.0%	28.3% (MH LHIN)	**287** more discharges to Rehabilitation	+66%
ED					
ED Visits Crude Rate	**310,573**	482.7	415.5	**43,220 Fewer visits**	-14%
CTAS Level I & II	52,361	81.4	65.0	10,516 fewer visits	-20%
CTAS Level III	119,583	185.8	171.6	9,146 fewer visits	-8%
CTAS Level IV & V	138,091	214.6	177.1	24,116 fewer visits	-17%
Emergency visit rate (age standardized 1-74) that could be treated in an alternative primary care setting	18,909	34.8	23.3	6,215 fewer visits	-33%

Moving forward, ESC LHIN will also be prepared to address the impact of health system funding reform, reshaping the system in order to address efficiency, effectiveness, and, most importantly, quality improvement. We believe that a transformation of bed capacity will be required in order to maintain a sustainable local system. One early notional framework suggests this can be accomplished through a reduction in acute care capacity with a concomitant expansion of rehabilitation capacity, complex continuing care, intensive complex continuing care, assisted living, and enhanced long-term care services (see Table 12). A rigorous, disciplined approach to utilization and evidence-based care will become vitally important over the next three years if we are to achieve our goals and objectives.

Table 12: Bed Type and Capacity, Three-Year Objectives (LHIN-Wide)

Bed Type	Current	Future	Percentage Change
Acute (medical/surgical)	678	603	-11
Sub-acute (rehab and CCC)	421	496	+18
Assisted living	150	225	+50
LTC	4,341	4,470	+3
Convalescent care	20	107	+434

ESC LHIN will also begin the process of examining and facilitating the integration of primary care services within the region. Building on MOHLTC strategies, ESC LHIN will:

- Analyze and enhance partnerships within the sub-LHIN (county) level through Health Links, in order to build on the natural patient-provider groupings existing within these sub-LHIN areas, and

- Build on the work completed to date that advances chronic disease management initiatives and telemedicine investments

ESC LHIN looks forward to working with the community in the next three years to address the challenges ahead as we bring better care, better experiences, and better value to Erie St. Clair.